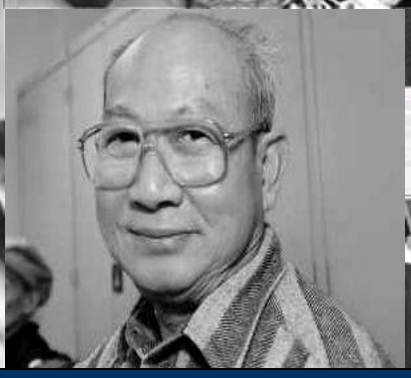
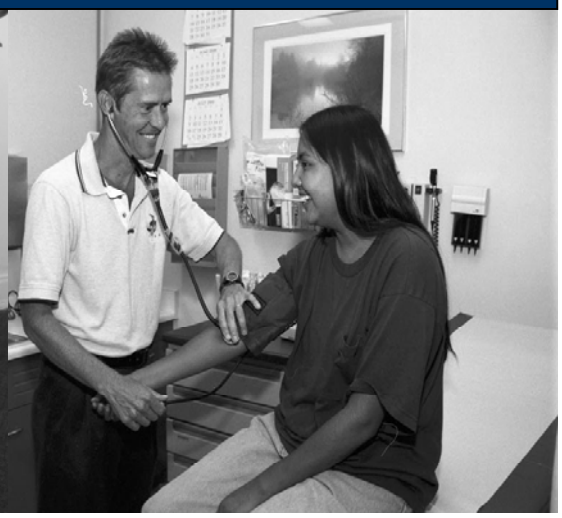


Appendices



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Appendix A – FY 2004 Top Management Challenges Identified by the Office of Inspector General

Management Challenge 1: Implementation of the Medicare Modernization Act (MMA)

Management Challenge:

At nearly 700 pages and 12 titles, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) sets forth the most comprehensive changes to the Medicare program since its inception in 1965. Implementation of this new statute is a huge undertaking involving massive dollars and complex new benefit programs.

Primarily, MMA establishes a new program in Medicare to provide a prescription drug benefit, Medicare Part D, which will become available on January 1, 2006. MMA also provides that Medicare beneficiaries may enroll in the Prescription Drug Discount Card program until the Part D benefit becomes available. In addition to the creation of new programs, MMA sets forth numerous changes to existing programs, including a revised Managed Care program, certain payment reforms, rural health care improvements, and other changes involving administrative improvements, regulatory reduction, administrative appeals, and contracting reform.

As a result of the creation of new programs and reform of existing programs, the Department of Health and Human Services (HHS) has acquired numerous new responsibilities. These include developing and implementing new programs, issuing regulations, conducting a variety of studies through surveys and audits, preparing and submitting reports to Congress, and enforcing program rules. Numerous components within HHS, including the Centers for Medicare & Medicaid Services (CMS), the Food and Drug Administration (FDA), the Agency for Healthcare Research and Quality (AHRQ), and the Office of Inspector General (OIG) have specific responsibilities set forth under MMA. Thus, implementation of MMA requires a high level of collaboration and coordination that extends across the Department to ensure these new programs and changes are implemented in such a way to guard against opportunities for waste, fraud, and abuse.

Assessment of Progress in Addressing the Challenge:

To address the challenges in implementing the numerous responsibilities HHS has under MMA, HHS has established MMA implementation teams and a tracking database. In addition, HHS components have set up various working groups to address MMA implementation issues. Components within HHS have already provided substantial assistance to one another with regard to implementation of MMA and will continue to coordinate HHS-wide to ensure HHS has fulfilled its responsibilities. Implementation of all provisions of this law merits significant thoroughness, scrutiny, and oversight.

Management Response:

Since enactment of the MMA, CMS leadership has involved the entire organization to implement numerous management initiatives to ensure the successful and timely implementation of the MMA.

Challenges:

Establishing Partnerships and Strategic Planning

CMS has established, both internally and externally, a number of cross-component leadership and staff level teams, that convene regularly in collaboration with HHS, to ensure major policy and operational issues are fully vetted and that critical program decisions are made in a timely manner. In addition, CMS has focused significant energy on strengthening its working relationships with other Federal agencies, including the Executive Office of the President, Office of Personnel Management, Small Business Administration, Social Security Administration, the Department of Labor, and the Department of the Treasury, to secure their necessary participation in MMA implementation activities.

CMS has also implemented both project planning and management reporting systems that afford CMS and Department leadership routine and timely information on critical timeframes, decision points, and the status of MMA implementation activities as well as summary information on the Agency's accomplishments. For example, the project plans developed for implementation of the new prescription drug benefit and the new Medicare Advantage program, both of which are effective on January 1, 2006, quickly highlighted the need for "Final Rules" implementing both programs to be published no later than January 2005. This will ensure adequate lead time for contracting for and operationalizing the new pharmacy benefit managers and for the health plans to develop and price the required new benefits, prepare marketing materials, and conduct open enrollment. Contractor reform is another area that CMS is undertaking to ensure that standards are met, and fraud, waste, and abuse are eliminated.

Resource Management

CMS has developed and implemented detailed financial plans to ensure that the resources Congress made available for implementation of MMA are fully leveraged and readily accessible in accord with the critical dates and milestones in the Agency's project plans. These plans, combined with the Agency's recently approved direct hire authority, have allowed CMS to recruit critical new skill sets that were previously unavailable in the Agency and are essential to successful implementation.

Education and Beneficiary Outreach

One of the major challenges to successful implementation is communicating the improvements and changes to beneficiaries and other stakeholders. CMS has invested heavily to ensure beneficiaries have access to the information they need, when they need it. The Agency has engaged beneficiaries and other stakeholders through 1-800-MEDICARE, www.medicare.gov, targeted open door forums, and town hall meetings. CMS has engaged numerous external organizations and other governmental agencies to help with outreach efforts. All efforts have been supplemented with awareness campaigns utilizing print, radio, and television media. For example, to ensure beneficiaries obtain maximum utilization of the time-limited Medicare Drug Discount Card, CMS and the Administration on Aging (AoA) recently made $4 million available to over 100 community-based organizations and coalitions representing nearly 700 individual organizations to help educate and enroll seniors in the Drug Discount Card program. In addition, over the next 2 years CMS will make over $50 million available to the State Health Insurance Assistance programs for outreach activities and training of their volunteers who provide one-on-one counseling to Medicare beneficiaries.

Accomplishments to Date:

CMS is responsible for implementing 416 separate MMA provisions within eight years (2003-2011). The legislation was intentionally front-end loaded, calling for 149 provisions (40 percent) to be implemented within the first six months. CMS implemented 91 percent of the provisions within the first six months after enactment and work is well underway for the remaining 15 provisions. CMS has published over 6,000 pages of regulations to ensure Congressional intent is carried out and has released 75 issuances that impact MMA provisions. Noteworthy accomplishments are highlighted below.

Medicare-Approved Prescription Drug Discount Card

The Medicare-Approved Prescription Drug Discount Card program is a bridge between the current lack of outpatient drug coverage for Medicare beneficiaries and the formal benefit effective in 2006. A prime example of CMS' management success is the full implementation of the new program within 6 months of enactment. Within 6 days of passage of the MMA, CMS published the "Federal Rules" establishing the Prescription Drug Card program, thus ensuring its timely implementation. CMS built an entirely new infrastructure to implement the drug card and developed a website to allow individuals to make educated and informed decisions regarding their prescription drug coverage. CMS augmented these efforts through partnerships with various pharmaceutical providers (pharmacy benefit managers, wholesalers, retail pharmacies, insurers, and Medicare Advantage plans), collaborations with external partners (AoA, States, beneficiary groups, etc.), and a comprehensive outreach campaign for Medicare beneficiaries. These efforts resulted in the enrollment of over 4 million beneficiaries through the end of August 2004. Beneficiaries have realized significant savings overall in addition to the $600 credit available to the most needy beneficiaries.

New and Improved Benefits

Beginning in 2005, Medicare will cover new preventive services. CMS proposed rules for these new preventive services, which include a one-time initial wellness physical exam, cardiovascular screenings, and diabetes screenings. These new benefits can be used to screen Medicare beneficiaries for many illnesses and conditions that, if caught early, can be treated and managed, and can result in far fewer serious health consequences. Such conditions as obesity, Diabetes, heart disease, and Asthma could be made far less severe for millions of Medicare beneficiaries.

Increased Beneficiary Choice and Access

CMS has already published "Final Rules" providing enhanced payments to institutional providers in rural and underserved geographic areas to increase beneficiary access to care. CMS has also proposed similar changes in provider payment and fee schedules to increase and expand beneficiary choice and access to care and to increase quality of care.

Quality

The MMA includes a number of provisions to improve beneficiary access to quality care. To date, CMS has implemented demonstration projects focusing on drug replacement alternatives for beneficiaries to receive cancer, arthritis, and multiple sclerosis medications in non-physician office settings, and on chronic care management alternatives. CMS has instituted numerous quality measures and reporting systems for hospitals to ensure beneficiary health and safety. In addition, the Agency is collaborating with the private

sector and other governmental agencies to establish an effective e-prescribing system as one component of the Department's vision for health information technology.

New Drug Benefit and Medicare Advantage

In late July 2004, CMS published proposed rules for the two largest components of the MMA, the Prescription Drug Plan and Employer Subsidy (Title I) and the Medicare Advantage program (Title II). As noted above, these regulations are effective January 1, 2006, but "Final Rules" must be published in January 2005. Title I will provide affordable prescription drug coverage and Title II will provide enhanced access to health care services.

Education and Outreach

Through the end of August, CMS has conducted 17 open door forums on MMA-related activities with 15,000 participants and numerous town hall meetings. In early March 2004, CMS launched the Medicare Modernization Update website to keep the public and provider communities informed of MMA implementation activities and plans. To date the website, which is updated monthly, has had over 124,000 "hits" and has over 5,500 subscribers. In addition, early this summer CMS enhanced the Medicare.gov website to include information on the Medicare-Approved Drug Discount Card program.

The timelines required under MMA for implementing these important new benefits are ambitious and have required prudent planning and a wise use of resources. The CMS has met and exceeded its required obligations for implementation of the MMA and is continuing to work diligently to accomplish the remaining tasks.

Management Challenge 2: Payment for Prescription Drugs

Management Challenge:

Numerous OIG and Government Accountability Office (GAO) reports consistently found that the Medicare and Medicaid programs pay too much for prescription drugs. These programs reimbursed drug costs based on inflated published average wholesale prices (AWP) rather than the prices actually paid by suppliers and physicians. For example, Medicare Part B payments for 24 leading drugs with the highest total Medicare payment in 2000 were $887 million higher than actual wholesale prices available to physicians and suppliers and $1.9 billion higher than prices available through the General Services Administration's Federal Supply Schedule. In an August 2001 report, OIG estimated that the Medicaid program could have saved as much as $1 billion if brand name prescription drug reimbursement (not including the dispensing fee) had been in line with the pharmacies' estimated acquisition costs for drugs. The OIG concluded that Medicare and Medicaid paid too much for prescription drugs because their payment methodologies are flawed.

The MMA changed the Medicare reimbursement of Part B drugs based on the vulnerabilities identified by OIG and GAO. Beginning in 2005, Medicare will pay for drugs based on the new average sales price (ASP) methodology. In 2006, MMA provides doctors with an annual choice between two payment and delivery systems. Physicians will have a choice of being paid 106 percent of ASP or having the drugs furnished to them by contractors selected by CMS using prices established through a competitive bidding process. Hopefully, these reforms will prevent the Medicare Part B program from paying inflated drug costs and more accurately reflect market prices.

MMA also created a *new* prescription drug benefit for Medicare beneficiaries. Prior to MMA, Medicare covered only a limited set of approximately 450 drugs under Part B. Effective January 2006, Medicare will provide a comprehensive drug benefit under the new Part D. Until 2006, qualified Medicare beneficiaries may receive discounts on their prescription drugs by enrolling in the temporary Prescription Drug Discount Card program. The expansion of Medicare drug heightens the significance of accurately and appropriately paying for prescription drugs.

The MMA did not address the AWP vulnerabilities in the Medicaid drug reimbursement. Therefore, most Medicaid State programs will continue to reimburse for pharmaceuticals based on inflated AWPs.

It is imperative to monitor these prices, whether provided through risk-bearing private plans or otherwise, to ensure that HHS is a prudent purchaser.

Assessment of Progress in Addressing the Challenge:

The MMA brings new responsibilities to HHS and increases the challenges in providing an adequate level of prudent oversight to the Medicare program. CMS has implemented the prescription drug discount card, promulgated MMA regulations for calculating ASP, is developing a plan for the selection of a payment safeguard contractor to audit the discount card program, and recently issued regulations on the new Medicare prescription drug benefit.

It is critical that the new Part B reimbursement methodology, the Medicare prescription drug discount card, and new Medicare prescription drug benefit are implemented in an efficient and effective manner and not be subjected to fraud, waste, and abuse. If history is an indicator of future events, then OIG's past experience in auditing, evaluating, and investigating Medicare and Medicaid drug reimbursement shows that HHS oversight needs to be especially vigilant in this area.

Management Response:

The CMS is committed to ensuring access to Medicare-covered prescription drugs while paying fair prices for them. The MMA modified the Medicare program to include coverage of prescription drugs under Part D in 2006 and market-based payment methodologies for covered Part B drugs and biologicals beginning in 2005. In addition as of June 2004, the Medicare-Approved Prescription Drug Discount Card and Transitional Assistance program affords qualifying beneficiaries the opportunity to receive help paying for drugs and access to lower prices prior to implementation of the new Part D drug benefit. Although implementing these reforms presents many challenges, CMS has successfully accomplished numerous initial tasks.

Medicare Drug Benefit – 2006 Forward

CMS has received comments on proposed regulations for implementing the Part D drug benefit and will develop final regulations and selection procedures within the next few months. Working closely with its State partners and the Social Security Administration – as well as its HHS partners – CMS will implement a number of systems and oversight activities to ensure the integrity of the drug benefit and operations of the program.

- CMS plans to collect data on drug claims, which will allow it to review beneficiary and plan costs and to appropriately implement the MMA's payment methodology;

- CMS is developing reconciliation processes to ensure that payments are appropriate; and

- CMS is developing comprehensive oversight and fraud and abuse plans.

Drug Card Sponsor Monitoring and Compliance Process - 2004-2005

CMS' approach for overseeing the Medicare-Approved Prescription Drug Discount Card program emphasizes analysis of program data to enable CMS to know where best to focus its program oversight, compliance, and enforcement resources. The oversight program utilizes the resources of CMS' central office, 10 regional offices, and a Medicare program safeguard contractor (IntegriGuard). CMS' response to program violations can include conducting educational calls with sponsors, issuing warning letters, imposing corrective action plans, levying civil monetary penalties, and imposing intermediate sanctions and terminating card sponsors from the program. Card sponsors thought to be engaging in fraudulent activities are referred to the HHS OIG or the Department of Justice.

Also, CMS has released six analyses on savings available to its beneficiaries under the Medicare-Approved Prescription Drug Discount Card program. These analyses consistently show the substantial savings available to Medicare beneficiaries, particularly those with low incomes.

Average Sales Price Methodology and Competitive Acquisition

CMS has received two quarters of ASP data from drug manufacturers, and is actively working with manufacturers to improve the quality of reporting. In addition, CMS has received comments on the MMA

regulations for calculating ASP and implementation of the ASP methodology, and has issued a "Final Rule" revising the estimation methodology for price concession data that is available on a lagged basis. Based on early ASP data, the new Part B reimbursement methodology will bring significant savings to the program and to beneficiaries. CMS is collaborating with the OIG on several tasks that are critical for ensuring the successful implementation of the ASP methodology. CMS looks forward to working closely with the OIG to evaluate and act upon ASP data that differs from widely available prices or Medicaid best price data as the statute permits. The Agency has begun a number of activities critical for timely implementation of the competitive acquisition program in 2006, in recognition that it is essential for the ASP methodology to be implemented accurately to set the basis for a successful competitive acquisition program.

Management Challenge 3: Bioterrorism Preparedness

Management Challenge:

The tragedy of September 11, 2001 and events since then underscore the importance of having a national health care infrastructure and resources to respond to threatened and actual acts of terrorism and bioterrorism, as well as other public health emergencies. Because HHS manages most of the Nation's Federal health resources through research, surveillance, coordination, and delivery of programs, OIG work has focused on vulnerabilities in those programs. The OIG assesses how well programs recognize and respond to outside health threats, the security of HHS laboratory facilities, the management of these grant programs and funds by the Department and grantees, and the readiness and capacity of responders at all levels of government to protect the public's health.

Since 2001, OIG has completed numerous audits and evaluations of the Department's programs for bioterrorism preparedness and response. In evaluating the effectiveness of the Centers for Disease Control and Prevention (CDC) bioterrorism preparedness efforts, OIG assessed the ability of 12 State and 36 local health departments to detect and respond to bioterrorist events. Additionally, the OIG conducted a review in 11 States and 21 localities of their ability to receive and deploy the National Pharmaceutical Stockpile (now known as the Strategic National Stockpile). The stockpile is designed to supplement and restock State and local public health agency pharmaceutical supplies in the event of a biological or chemical incident. In both studies, the OIG found these States and localities were under-prepared both to detect and respond to bioterrorist events in general, and that their planning documents tended to overstate preparedness. At CDC's request, the OIG conducted follow-up reviews of progress made by the same States and localities. The OIG noted that while some progress had been made, CDC needs to continue working with States and localities to ensure that a priority planning system is in place.

The OIG also reviewed States' progress in developing and implementing jurisdiction-wide laboratory response programs for bioterrorism, which included Level A laboratories. These Level A laboratories are clinical labs that may be involved in the early detection of a bioterrorism event and can conduct initial testing to rule out critical agents of bioterrorism (such as Anthrax) and refer suspected specimens to higher level laboratories. They are generally hospital-based, freestanding, or local public health laboratories. The OIG found that virtually all States had begun creating their programs by drafting plans and identifying, contacting, educating, and assessing the capabilities of at least some Level A laboratories. However, the OIG noted key vulnerabilities, including insufficient training, a lack of critical emergency communication systems, and States' use of inconsistent standards to identify Level A laboratories. The OIG also performed reviews in 14 States and four major metropolitan areas assessing grantees' efforts to comply with the financial accounting and reporting requirements of CDC's and the Health Resources and Services Administration's (HRSA) bioterrorism grant programs. The OIG found that grantees did not always follow program regulations with respect to recording, summarizing, and reporting bioterrorism grant expenditures; monitoring subrecipient expenditures; and timely obligating grant funds.

In the period following the terrorist attacks, the OIG assessed security at laboratories operated by CDC, the National Institutes of Health (NIH), FDA, and several colleges and universities, as well as CDC's role in regulating select agents. In FY 2004, the OIG followed up on its original assessment of security controls at Departmental laboratories and found that the Agencies had implemented, or developed plans to implement, most of its prior recommendations. Because legal requirements for the possession of select agents have become more stringent and detailed in the last several years, the OIG plans to conduct additional audits to

determine if the entities using select agents have security programs that comply with these requirements and to assess CDC's regulatory oversight.

The OIG also initiated reviews to examine hospitals' planning and preparedness to deal with surge capacity (an overwhelming number of human casualties and injuries) in the event of a bioterrorist event as part of their use of HRSA Hospital Bioterrorism program funding; State health departments' 24-hour, 7-day-per-week urgent disease reporting systems; and accountability for funds under the Hospital Bioterrorism program and the CDC Bioterrorism Cooperative Grant. Additionally, with the Department of Homeland Security and Environmental Protection Agency OIGs, the HHS OIG will evaluate respective roles for shared responsibility of implementation of the BioWatch program, which is a joint program of surveillance for environmental exposure caused by intentional release of biological agents.

Assessment of Progress in Addressing the Challenge:

HHS Agencies have sought additional resources and are working on corrective action plans responsive to OIG-reported concerns. Federal, State, and local health departments are striving to work cooperatively to ensure that potential bioterrorist attacks are detected early and responded to appropriately. CDC has taken steps to expand the availability of pharmaceuticals needed in the event of chemical, biological, or radiological attacks. States and localities are currently strengthening their bioterrorism preparedness programs, and recent increases in HHS funding address some of the OIG's concerns. However, the OIG continues to believe that the general readiness of State and local governments to detect and respond to bioterrorist attacks is below acceptable levels. Until the OIG confirms that its recommendations regarding laboratory security have been implemented, it also remains concerned about significant vulnerabilities in this area.

Management Response:

CDC:

To address the challenges associated with public health emergencies and terrorist threats, CDC continues to intensify its efforts to increase the preparedness and response capacity of the Nation's public health system. CDC has taken steps to implement the changes recommended in the FY 2003 *PAR*. CDC's major contributions to this effort include:

- Investments in strengthening early detection and containment of biological public health threats including:
    - BioSense: CDC is connecting multiple disparate data sources into a fully functioning, real-time surveillance system to allow Federal, State, and local health officials access to real-time data that will help identify and characterize the nature of a bioterrorist attack or public health emergency.
    - Quarantine: Increasing the number of quarantine stations and upgrading current facilities to handle modern day threats.
    - Electronic Lab Reporting: Standardized systems in place to send lab results to CDC from the BioWatch laboratories.
    - Rapid Toxic Screen: A series of analyses that can rapidly screen human blood and urine samples for 150 chemical agents.

- Laboratory Response Network (LRN): Number of labs has risen to 126, up from 91 in 2001. These labs are now located in all 50 States and the LRN even boasts several installations abroad.
    - 96 percent of these labs can confirm the presence of Anthrax, 94 percent can confirm Tularemia, and 63 percent can perform presumptive screening for Smallpox.
    - More than 8,800 clinical laboratorians have been trained to play a role in the detection, diagnostics, and reporting of public health emergencies.
    - More than 4,400 bioterrorism-capable laboratories have been identified and a list has been made available to CDC and State and local public health partners.

- Investments in the ability to communicate with public health and health care partners:
    - A secure web-accessible database has been expanded to reach 180,000 clinical and public health laboratories.
    - Epi-X, the Epidemic Information Exchange, enables CDC to provide secure, moderated communications and notification services. Currently there are an estimated 3,000 users, with that number expected to increase to over 5,000.
    - Public Health Information Network (PHIN) is focusing its efforts on integrating several systems into a unifying framework to better monitor applicable data streams for early detection.
        - PHIN will enable consistent, secure exchange of response, health, and disease tracking data between public health partners.
        - PHIN is composed of five key components: (1) detection and monitoring, (2) data analysis, (3) knowledge management, (4) alerting, and (5) response.
    - Established the Emergency Communications System for information creation and distribution during an event.

- Invested in response capabilities:
    - The Cities Readiness initiative began in late FY 2004 with the goal of increasing the ability of localities to rapidly and effectively distribute the contents of the Strategic National Stockpile in the event of a terrorist or hazardous event. The initial 21 cities will be used as a test program to garner best practices that can be expanded to other location throughout the Nation.
    - Funds and technical assistance to 62 grantees building preparedness and emergency response functions at State and local health departments.

- Established the Director's Emergency Operations Center as CDC's "headquarters" for managing a public health event or emergency, exercised during hurricane response of 2004.

FDA:

The OIG previously conducted audits of 11 FDA laboratories, assessing physical security and security controls on the labs containing select agents. During their audits, the OIG made over 300 recommendations. In FY 2004, a series of follow-up audits were conducted by KPMG. KPMG's audits found that over 92 percent of the OIG's recommendations had been fully implemented by alternate actions, or were in the process of being implemented. FDA actions taken since KPMG's audit now put the number at over 96 percent. The FDA is continuing its efforts to strengthen the security of its select agent labs. These efforts include the installation of biometric readers, motion detectors, and closed circuit television cameras with digital recording for all FDA select agent laboratories. Additional closed circuit television cameras are being installed around laboratory building perimeters, parking lots, and loading docks.

Management Challenge 4: Integrity of Medicare and Medicaid Payments

Management Challenge:

For FY 2003, the Medicare, Medicaid and State Children's Health Insurance Program (SCHIP) benefit payments totaled about $433 billion, which represents payments by Medicare contractors, CMS, and Medicaid State agencies to health care providers for their services. In view of the 42 million Medicare beneficiaries, 42.9 million Medicaid enrollees, over 1 billion Medicare claims processed and paid annually, complex reimbursement rules, decentralized operations, and health care consumers who may not be alert to improper charges, the Medicare and Medicaid programs are at high risk for payment errors.

Medicare

From FY 1996 through FY 2002, OIG developed and reported on the annual Medicare Fee-for-Service paid claims error rate. In FY 2003, CMS assumed responsibility for the error rate development. In its 2003 financial report, CMS reported an adjusted error rate of 5.8 percent ($11.6 billion) and an unadjusted rate of 9.8 percent ($19.6 billion) for the FY.[1]

The unadjusted rate reflects an unusually high rate of nonresponse by the providers in the sample (54.7 percent) to requests for medical records. CMS believes that this was due to the impact of Health Insurance Portability and Accountability Act (HIPAA) privacy rules, record requests made by an unfamiliar entity, and general difficulties with providers' unresponsiveness to record requests. CMS adjusted the nonresponse rate to reflect OIG's years of experience with nonresponsiveness.

Targeted audits and inspections by OIG and CMS itself continue to identify improper payments and problem areas in specific parts of the program. These reviews have revealed payments for unallowable services, inpatient hospital transfers to postacute care settings improperly coded as home discharges, community mental health center excessive outlier payments, and other types of improper payments. For example, the OIG found over $45 million in improper payments for equipment and supplies separately billed by durable medical equipment suppliers for beneficiaries residing in skilled nursing facilities. OIG and CMS discovered substantial abuses of medical equipment suppliers billing Medicare for power wheelchairs that were never delivered, equipment that was medically unnecessary, and billing for high-cost equipment when lesser-cost equipment was provided. Similarly, the OIG found that a major hospital had manipulated the Medicare rules for outpatient outlier payments, receiving a disproportionate share of these payments because of dramatic increases in billed charges.

OIG audits continue to show that Medicare has serious internal control weaknesses in its financial systems and processes for producing financial statements. For example, the reporting mechanism that Medicare contractors use to reconcile and report funds expended depends heavily on inefficient, labor-intensive, manual processes subject to the increased risk of submitting inconsistent, incomplete, or inaccurate information to CMS. These matters are indicative of serious systemic issues that must be resolved.

[1] CMS' performance target for FYs 2002 and 2003 was 5 percent and drops to 4.8 percent in FY 2004.

Assessment of Progress in Addressing the Challenge:

The FY 2003 adjusted error rate is less than half of the 13.8 percent reported in FY 1996. CMS has demonstrated continued vigilance in monitoring the error rate and developing appropriate corrective action plans. In addition, due to CMS's work with the provider community to clarify reimbursement rules and to impress upon health care providers the importance of fully documented services, the overwhelming majority of health care providers follow Medicare reimbursement rules and bill correctly.

CMS has taken a number of steps to strengthen Medicare coverage and reimbursement requirements to help curb inappropriate payments. For example, CMS has agreed to establish or enhance billing controls to ensure compliance with the consolidated billing provision, identify "best practices" in both consolidated billing and postacute care transfers, and aggressively scrutinize new applications for durable medical equipment supplier numbers.

CMS received an unqualified opinion on its 2003 financial statements. However, the lack of a fully integrated financial management system and insufficient oversight of the Medicare contractors continued to impair the reporting of accurate financial information. Weaknesses were identified in general and application controls at Medicare contractors, at data centers where Medicare claims are processed, at sites that maintain the "shared" application system software used in claims processing, and at the CMS central office. In addition, although there were improvements in CMS's oversight of Medicare contractors, continuing weaknesses affected CMS's ability to analyze and accurately report financial information on a timely basis.

To address these problems, CMS has initiated steps to implement the Healthcare Integrated General Ledger System (HIGLAS), expected to be fully operational at the end of FY 2007. In the interim, corrective action is needed to address persistent weaknesses in internal controls throughout the Medicare system.

Medicaid

Payment accuracy in the Medicaid program helps ensure fairness across all State Medicaid programs and also ensures that State and Federal health care dollars reach and achieve their maximum intended health care purposes. Until recently, little was known about payment error rates in the Medicaid program. This represents a substantial vulnerability in preventing fraud, waste, and abuse perpetrated by health care providers. Understanding errors is particularly difficult due to the varied nature of State programs and their unique administrative and control systems.

In addition to provider payment fraud and abuse, the OIG is aware of significant problems in State Medicaid financing arrangements involving intergovernmental transfers, upper payment limits, and disproportionate share payments to hospitals. The OIG found that some States inappropriately inflated the Federal share of Medicaid by billions of dollars by requiring public providers to return Medicaid payments to the State governments through intergovernmental transfers. Once the payments were returned, the States used the funds for other purposes, some of which were unrelated to Medicaid. Although this abusive practice could potentially occur with any type of Medicaid payment to public facilities, and is not legally prohibited, the OIG identified serious problems with this practice in Medicaid enhanced payments available under upper payment limits and Medicaid disproportionate share hospital payments. These Federal/State enhanced payments are made to nursing homes or hospitals, and these facilities then return the monies to the States through intergovernmental transfers.

Assessment of Progress in Addressing the Challenge:

In July 2001, CMS invited States to participate in a demonstration project to develop a payment accuracy measurement (PAM) methodology for Medicaid, i.e., a single methodology that can produce both State-specific and national level payment error estimates for Medicaid and SCHIP. The PAM model was later modified to comply with the new requirements of the Improper Payments Information Act of 2002. CMS will produce the final specifications for the CMS model of the PAM project at the conclusion of year 3. As required by the Improper Payments Information Act, the new model refers to erroneous payment and/or payment error, not payment accuracy. FY 2004 is the final year of pilot testing.

On June 20, 2003, CMS solicited proposals from States interested in voluntarily participating in year 3 (FY 2004) of the PAM project. Twenty-seven States in total received PAM project grants to test the CMS model in their Medicaid and/or SCHIP programs. Year 3 was the first year SCHIP programs were included in the PAM project.

The PAM project will be implemented nationwide in FY 2006 through regulation and renamed the Payment Error Rate Measurement (PERM) program. CMS will require all States to participate in PERM beginning in October 2005 (FY 2006). This year the OIG has reviews underway to oversee and monitor the PAM project and States' implementation of the core requirements.

To curb abuses in the State Medicaid financing arrangements, CMS issued "Final Rules" (effective March 13, 2001, November 5, 2001, and May 14, 2002), which modified upper payment limit regulations in accordance with the Benefits Improvement and Protection Act of 2000. The regulatory actions created three aggregate upper payment limits-one each for private, State, and non-State government-operated facilities. The new regulations will be gradually phased in and become fully effective on October 1, 2008. CMS projects that these revisions combined will save $90 billion in Federal Medicaid funds over the next 10 years.

However, when fully implemented, these changes will only limit, not eliminate, the amount of State financial manipulation of the Medicaid program because the regulations do not require that the targeted facilities retain the enhanced funds to provide medical services to Medicaid beneficiaries. The OIG also believes that the transition periods included in the regulations are longer than needed for States to adjust their financial operations.

CMS has developed procedures for conducting financial management reviews to ensure State accountability with respect to disproportionate share payments to hospitals. The OIG is continuing audit work in this area and will recommend program improvements once the work is completed.

Management Response:

The OIG's assessment of progress for addressing this challenge is correct. CMS is working aggressively with the Comprehensive Error Rate Testing contractor and the OIG to follow up with providers to reduce the nonresponse rate in the development of the annual Fee-for-Service payment error rate. In addition, CMS initiated "Operation Wheeler Dealer" to reduce fraud and abuse in supplier billing of power wheelchairs. CMS plans to issue improved guidance to clarify power wheelchair coverage, enhance coding requirements, and facilitate billing through a consolidated mobility Certificate of Medical Necessity.

On July 13, 2004, CMS solicited proposals from States interested in voluntarily implementing the PERM pilot program. The States will review a small sample of Medicaid and SCHIP claims and determine a payment error rate. CMS also published a "Proposed Rule" on August 27, 2004, which would require States to annually estimate their payment error rate in the Medicaid and SCHIP programs.

Management Challenge 5: Nursing Facilities

Management Challenge:

With the large number of people approaching retirement, there is a significant need to remain vigilant in ensuring quality of care on behalf of long-term care beneficiaries so that Federal dollars are well spent purchasing appropriate care for nursing home recipients today and in the future.

OIG has had longstanding concerns regarding payment and quality issues in nursing facilities. Many family members are uncertain about the quality of nursing home care provided to their loved ones. Indeed, in prior work, the OIG found increases in the total number of deficiencies and in the proportion of nursing homes being cited for substandard care deficiencies. In addition, OIG work identified inconsistencies in how deficiencies are cited by the various State survey agencies, which resulted from variations in survey focus, unclear guidelines, lack of a common review process for draft survey reports, and high turnover of surveyor staff.

Nursing home residents and their families may not be receiving the most current information regarding the quality of care in nursing homes. For example, in the OIG's recent evaluation of the accuracy of the information in the Medicare Nursing Home Compare website, while it noted that almost all Medicare and Medicaid nursing homes were included in this database, 19 percent of these nursing homes had one or more surveys missing.

OIG continues to find vulnerabilities in programs that are to ensure quality and protect residents of nursing homes. When it examined the accuracy of the nurse aide registries maintained by States, it found that some States failed to adequately update registries with information on substantiated adverse findings against nurse aides. In fact, some individuals with criminal records in one State were actively certified in other States, and some in multiple States. Without accurate nurse aide registry information, nursing homes may inadvertently hire aides who have committed such offenses as abuse, neglect, and theft, thus placing residents at considerable risk.

Most recently, the OIG completed the first in a series of reports related to enforcement actions used by CMS and States to address deficiencies in quality of care or safety standards. In this report, it found that while $81.7 million in civil monetary penalties (CMP) were imposed during 2000 and 2001, CMS had collected only $34.6 million (42 percent) by the end of 2002. Low imposition rates and slow and/or difficult collection efforts may minimize the effect that CMPs ultimately have on noncompliant facilities. The OIG is concerned that enforcement mechanisms may not be working in a sufficiently effective manner to bring nursing homes with serious deficiencies back into compliance in the interest of quality of care for residents.

Some nursing home care problems are so serious that they constitute "failure of care" and thereby implicate the False Claims Act. OIG continues to work with U.S. Attorneys' Offices and the Department of Justice on development and settlement of these egregious cases. It develops exclusion actions against individuals and entities whose actions cause the furnishing of poor care, with particular emphasis on higher-level officials of nursing facilities and chains. The OIG continues to negotiate quality-of-care Corporate Integrity Agreements (CIAs) as part of the settlement of such False Claims Act cases. All of these CIAs require an outside monitor and include effective enforcement remedies for breach of the CIA, such as specific performance, stipulated penalties, and exclusion. Currently there are 10 active quality-of-care CIAs that cover approximately 1,000 nursing facilities. Additionally, the OIG ensures that long-term

care providers are implementing quality-of care-CIAs appropriately. It continues to fine-tune provisions of the quality-of-care CIAs and to develop uniform guidelines and practices for quality monitors and means of measuring success of existing CIAs.

OIG is continuing to devote considerable resources to monitor the overall quality of care provided in nursing homes, track the adequacy of enforcement actions, and evaluate the adequacy of processes designed to safeguard nursing home residents. While its work is generally directed to assessing the effectiveness of Medicare and Medicaid nursing home quality-of-care enforcement and assurance systems, the OIG is also conducting inspections to identify and describe promising practices being undertaken by nursing homes to improve the care and quality of life of their patients.

OIG is also concerned whether payments to nursing homes are made correctly and whether the funds are being used for patient care-related activities. It is now examining the adequacy of Medicaid payments to nursing facilities in States that have enhanced payment programs for public nursing facilities. As part of these studies, the OIG is determining whether Medicaid reimbursements to States for nursing home care are being diverted from the nursing homes to other State programs.

For instance, the OIG found that a nursing home in New York State was required by the State and county to return about 90 percent of its enhanced funding, despite the fact that the nursing home had received the most unfavorable rating that a State can issue. If the nursing home had retained more of its enhanced funding, it might have provided better quality of care.

Assessment of Progress in Addressing the Challenge:

CMS has undertaken several initiatives to strengthen the survey and certification process. For example, it has developed clearer guidance for State survey agencies that will enable their surveyors to better identify specific deficiencies and investigate whether a deficiency is a result of substandard care. It also plans to provide additional guidance to these agencies to improve their complaint investigation process. Additionally, CMS indicated that it would require State agencies to verify the most recent inspection results, which are contained on the Nursing Home Compare website.

Management Response:

CMS has engaged a number of approaches to improve and refine a number of survey and certification actions, protocols, survey tools, and State agency guidance/instruction. The OIG has touched on a number of concerns ranging from enforcement actions, Nursing Home Compare data, inconsistencies in deficiency citations, and the nurse aide registries.

In Fall 2004, CMS will implement, in all States, a new, electronic automated enforcement manager for all types of enforcement actions in nursing homes. CMS and States annually conduct a vast number of on-site visits or investigations to the Nation's nursing homes. Investment in critical infrastructure to ensure appropriate tracking and management of enforcement actions, though usually "unseen" and unglamorous, is vital. Implementation of the electronic enforcement manager represents an important milestone.

The work of Federal and State officials has resulted in a survey and certification process that is demonstrably better than in the past. For example, CMS' new State Performance Standards System provides specific feedback to States on 18 different indicators (seven main measures plus multiple

submeasures). Considerable progress has been made in a number of quality measures for nursing homes. These include reducing restraints, (reduced by about 15 percent from 1999 through 2003), reducing the prevalence of dehydration (reduced by about 41 percent), and reducing the prevalence of weight loss (down about 10 percent).

The OIG finding that 19 percent of the nursing homes on Nursing Home Compare website had one or more surveys missing, initially concerned CMS greatly. However, CMS has since determined that most of the "missing" data were instead "slow or delayed" data, and that the ability of consumers to rely on the website is not significantly impaired as a result. CMS would further note that, while OIG uses the term "late data entry," such inputs are not always "late." Informal dispute resolution requirements, appeals, settlements, and other factors may require an interruption of the process while nursing homes are afforded due process. The data are entered when it is appropriate according to any additional time that was used by the adjudication process. To address the above phenomena, CMS posts the most recent past three surveys.

In terms of the OIG's recommendations on the vulnerabilities associated with the failures to adequately update State nurse aide registries, CMS has provided the State agency directors guidance and instruction on the law and CMS policy, as well as the importance of the nurse aide registries. The guidance included instructions that: (1) all findings of abuse, neglect, and misappropriation of resident property must be included in the nurse aide registry by the State survey agency within 10 working days of the finding, and (2) the names of nurse aides who have performed no nursing or nursing-related services for 24 consecutive months must be promptly removed from the nurse aide registry. In addition, through its regional offices, CMS will formalize expected follow up with some of the States that seem to have the most serious problems in maintaining an effectively functioning nurse aide registry system.

Management Challenge 6: Grants Management

Management Challenge:

Departmental discretionary grants, estimated to total over $37 billion in FY 2004, must be used appropriately to achieve their intended purposes. Many HHS Agencies rely on the grant and cooperative agreement mechanisms as pivotal tools in meeting mission objectives, such as providing critical health and social services to underserved individuals, researching the causes and treatments of disease, elevating the social and economic status of vulnerable populations, and supporting the nationwide infrastructure for the health surveillance and prevention network.

These programs are numerous and diverse, and vigilance is required to ensure that specific awards are well managed and free of abuse, and that the monitoring systems used to manage them can identify and respond to management challenges and improper behavior, including possible conflicts of interest that could undermine the integrity of the grant process. It is incumbent upon HHS to award these funds to the most worthy and competent organizations and to adequately monitor program performance and results, as well as the use of Federal funds.

Because of these inherent vulnerabilities, the OIG initiated reviews that focus on the effectiveness and efficiency of management controls over Federal grants. The OIG is systematically studying several HHS Agencies' grant-making and oversight processes. At the same time, it is assessing individual grantees' program performance-based outcomes and stewardship of funds. This strategy is designed so that findings and recommendations derived at the Agency level can be used in examinations at the grantee and subgrantee level and vice versa.

Thus far, primarily through its recent reviews of Acquired Immunodeficiency Syndrome/Human Immunodeficiency Virus (HIV/AIDS) grants programs, the OIG has found inadequate performance on the part of some grantees in achieving grant objectives, limited required reporting to Federal offices on progress in meeting program objectives, and the misuse of grant funds. In addition, the OIG noted poor oversight on the part of Federal program offices and inadequate follow up on significant identified problems. The OIG also conducted oversight work at NIH, examining the causes and impact of late awards by NIH and late closeouts by grantees. The OIG made several recommendations to NIH to improve the timeliness of awards and to better monitor the closeout process.

The OIG has initiated several related reviews, including reviewing the extent to which the Administration for Children and Families (ACF) ensures adequate State monitoring of subgrantees in the Foster Care program; examining the use of the Departmental Alert List of high-risk grantees as a grants management tool by CDC and HRSA; and determining the extent to which single audits assess universities' compliance with time and effort reporting requirements among NIH grantees.

The OIG has a special interest in controls related to ethical considerations. It is imperative that program administrators and grantees adhere to ethical standards that preclude conflicts of interest that could negatively affect program outcomes. Both the grantees and the HHS program administrators must be ever-vigilant to ensure that conflicts of interest are prevented in the extramural research arena.

The importance of safeguarding the integrity of HHS research dollars was recently illustrated by an audit of a HRSA cooperative agreement implementing an HIV/AIDS peer treatment education program at a major university. The OIG found that the university had not resolved a conflict of interest situation in which the program's co-principal investigator was at the same time a university employee hired specifically for the

program and also the chief executive officer of the subcontractor. At a minimum, this "one person wearing two hats" situation gives the appearance that the expenditure of Federal funds was not adequately safeguarded. The school agreed to strengthen its procedures for identifying, reviewing, and resolving potential and actual conflicts of interest.

As the OIG continues to investigate conflicts of interest at the grantee level, it recognizes a corresponding need to ensure that Departmental systems are also effective in preventing and detecting internal conflicts of interest and is encouraging maximum compliance by HHS employees. The OIG expects to issue the results of its assessments at both the grantee and Departmental levels in FY 2005. Because of their critical nature, these assessments will be reported separately from the OIG's grant management work.

Assessment of Progress in Addressing the Challenge:

Through the government-wide Federal Grant Streamlining program, the HHS grant management environment is undergoing significant changes. The program is intended to implement the Federal Financial Assistance Management Improvement Act of 1999 (Public Law (P.L.) 106-107), which requires agencies to improve the effectiveness and performance of their grant programs, simplify the grant application and reporting process, improve the delivery of services to the public, and increase communication among entities responsible for delivering services. The initiative requires grant officials to examine the way they do business, focusing not only on streamlining the grant process but also on ensuring that results are achieved and Federal funds are used appropriately for the maximum benefit of program recipients.

Additionally, it is crucial that HHS agencies adequately manage and monitor their grantees and, to the extent possible, their subgrantees' program performance and require fiscal accountability.

Management Response:

The Office of Grants Management and Policy (OGMP), under the Office of the Assistant Secretary for Administration and Management, continues to conduct a variety of Departmental activities which complement the various studies being conducted by OIG. OGMP activities include targeted reviews of HHS grant programs, P.L. 106-107 activities to streamline the grants process, Grants.gov to allow grant applicants the ability to find and apply for grant opportunities in one place, balanced scorecard (BSC) surveys to measure the reliability of grant administration processes across the Department, collaboration with OIG to improve Agencies' use of the Alert List, and Departmental review of funding opportunity announcements.

OGMP has initiated targeted reviews to ensure that grant practices are in compliance with established Departmental grant policies and regulations. These reviews focus on evaluating preaward processes, examining postaward monitoring activities (including performance and financial report submissions), improving consistency between Agencies, and identifying best practices to share across the Department. To date, the reviews have identified mismatches in policy documents and flawed business processes, as well as some Agency-specific practices that could serve as models across the Department. OGMP has worked collaboratively with OIG in conducting targeted reviews, so that each office is kept abreast of the various grant oversight activities and reviews being conducted. Beginning in FY 2005, OGMP will advise Agencies of those discretionary grant programs that have been designated for review in the upcoming fiscal

year. In FY 2006, OGMP plans to increase the number of grant program reviews conducted annually. Also, the results of the OIG reviews and studies are being analyzed by OGMP so that appropriate strategies for generalizing solutions across programs can be developed and shared through effective training modules with Departmental staff responsible for monitoring grantee and subgrantee performance based outcomes and stewardship of funds. Through effective training, Departmental staff will be able to achieve improvement in these areas.

HHS' Grants Management BSC is a self-administered review protocol enabling HHS Agencies to assess perceptions of performance by soliciting feedback from a variety of internal and external users/customers. The results provide indicators as to how well an HHS Agency is performing a variety of preaward and postaward grant monitoring activities, enabling HHS Agencies to develop and implement action plans to address areas targeted for improvement. Beginning in second quarter FY 2005, all HHS Agencies will administer Phase One of the BSC (which consists of internal HHS Agency surveys; Phase Two consists of external surveys of grant recipients). HHS Agencies' results from this second initiation of BSC surveys will be compared to those results from the 2003 survey results (where applicable). HHS Agencies such as HRSA, AHRQ, and AoA, for example, developed and implemented process improvements after the 2003 surveys. OGMP anticipates that their improvements will be reflected in the 2005 round of surveys.

Grants.gov is a government-wide electronic government (e-Gov) initiative managed by HHS, working in collaboration with the 26 Federal grant-making agencies. The deployment of the Grants.gov portal was a major step taken to migrate all Federal agencies to the envisioned system called for by the President's Management Agenda and P.L. 106-107. Deployment of the portal assists the Agencies in meeting their mission objectives by providing a common system to support interactions with the grants community, which includes potential applicants, applicants, and grantees. Grants.gov's *Find* functionality (www.grants.gov/Find) allows Federal agencies to post discretionary grant opportunities on Grants.gov and potential applicants to conduct a search of these opportunities. Since October 2003, all grant-making agencies have posted their discretionary funding opportunities on Grants.gov. As of October 5, 2004, over 4,200 Federal discretionary grant opportunities have been posted. HHS has posted approximately 1,430 opportunities since October 2003. Grants.gov's *Apply* functionality (www.grants.gov/Apply) allows Federal agencies to post their application packages on Grants.gov, and allows applicants to download the application package and complete it offline based on agency instructions. After applicants have completed all required forms, they can electronically submit the package to Grants.gov. Upon receipt of the application, Grants.gov sends an electronic acknowledgment to the applicant and delivers the application to the Agency. The Grants.gov *Apply* functionality was launched in October 2003. As of October 5, 2004, approximately 185 application packages have been posted by Federal agencies and 1,090 electronic applications have been received from the grants community. HHS has posted 120 application packages and received 657 electronic applications. HHS has also developed a "ramp up" schedule for posting application packages on Grants.gov, and has scheduled or completed system-to-system integration testing with ACF, HRSA, and NIH.

The HHS grants management environment is continuing to undergo changes. The grant streamlining initiative is a government-wide effort required by P.L. 106-107, which requires all Federal agencies to improve the effectiveness and performance of their grant programs, simplify the grant application and reporting process, improve the delivery of services to the public, and increase communication among entities responsible for delivering services. As the lead agency in this multi-year initiative, HHS continues to provide both strategic oversight for the Act's implementation as well as a leadership role in the various streamlining and simplification work groups. Achievements to date include, but are not limited to: (1) the

establishment of the Grants.gov *Find* data elements for the Grants.gov portal which allows applicants to find grant opportunity announcements in one centralized location (Grants.gov); (2) the Standard Grant Announcement Template which enforces a single way of formatting grant funding announcements across the 26 grant-making agencies; (3) registration with Dun and Bradstreet for a DUNS number, thereby allowing all grantees to have a single unique identification number across the government. This will enhance the traceability of grant funds from Federal agency to Federal agency; (4) consolidation of all OMB guidance and Federal agency implementing regulations to a new Title (2 CFR) so that grant applicants and awardees can look to one place to find the Federal grant administrative policies and regulations; and (5) a new Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations'* single audit threshold of $500,000 in order to decrease the single audit burden on very small grantee organizations. OGMP within HHS leads this effort through collaboration with all 26 Federal grant-making agencies and Grants.gov in order to realize the requirements for P.L. 106-107; and has several internal HHS Executive Committee on Grants Administration and Policy subcommittees that specifically address the implementation of P.L. 106-107 and Grants.gov within the Department.

HHS, in collaboration with OIG, is working to improve Agency use of the HHS Alert List as a grants management tool. HHS maintains its Alert List in order to notify all HHS awarding offices of entities considered "high risk/special award conditions" by one or more awarding offices and/or those for which the OIG has issued an alert. This allows other Agencies to decide whether they should include special terms and conditions in awards they make to the same entity. If an award contains special conditions, the HHS Agencies must ensure that the grantee is aware of those conditions and understands the action that is necessary to satisfy them. Furthermore, HHS Agencies develop a corrective action plan with the affected grantee, monitor improvement, and assess, at the conclusion of the corrective action period, whether the special award conditions can be removed.

As one of several initiatives designed to ensure that the Department meets the President's Management Agenda goal for improving the management and performance of the Federal Government, OGMP was authorized by the Secretary to conduct a Departmental review of grants management activities involving the pre-award process. Special interest was given to the development of funding announcements in order to afford greater efficiencies and increased accountability, and ensure that announcements are consistent with regulations and Departmental policies. The Departmental review has identified various recommendations for improvements in announcement preparation and presentation, which have subsequently been promulgated through a directed action transmittal to the awarding components. The FY 2004 review had a special focus to ensure that Agencies' funding opportunity announcements were compliant with OMB's new policy directive requiring the use of a government-wide standard program announcement format. All HHS Agencies are implementing the standard format and, as a result, program announcements have greater consistency across the Department. In FY 2005, the next steps will be integrating "Topic Area" comparisons between Agencies into the reviews, having 100 percent compliance with OMB requirements including use of Grants.gov and the OMB standard announcement format, and any additional requirements directed by OMB as the result of ongoing P.L. 106-107 initiatives.

HHS and OGMP have implemented various methods for assuring compliance to 5 CFR 2635, *Standards of Ethical Conduct for Employees of the Executive Branch*. HHS has a financial disclosure and outside activities approval requirement that all grants management and program officials within the Department (who have responsibilities that affect non-Federal entities) must complete in order to anticipate/avoid any conflicts or interest. In addition, HHS has an ethics training requirement that all HHS management must adhere to on an annual basis. OGMP has a grants management training course entitled "New Orientation

for Quality Grants Management" that has a module/video on grantsmanship ethics. This training course has been required for Level I grants management certification. Further, OGMP encourages grants management offices to perform grants management financial/business process site visits to the grantees in order to identify any financial/business process internal control weaknesses. If weaknesses are found, grantees are required to submit corrective action plans which, if necessary can be, placed in the terms and conditions of the grant award. Ineffective compliance to the correction of a "weakness" as identified in the terms and conditions can result in a suspension or termination of the grant.

All of the initiatives referenced above require grant officials throughout the Department to examine their current business processes. The Department anticipates that through the implementation of the aforementioned initiatives, grant officials will not only focus on streamlining the various HHS grant processes but, also ensure that: (1) appropriate methods are put in place to achieve programmatic goals and objectives, (2) collection and distribution of meaningful evaluation data will be enhanced, and (3) effective stewardship of all Federal funds will be achieved.

Management Challenge 7: Protection of Critical Systems and Infrastructure

Management Challenge:

Through Presidential Decision Directive 63, the Federal Information Security Management Act (FISMA), and Homeland Security Presidential Directive 7, the Federal Government has been mandated to assess the controls in place to protect assets critical to the Nation's well-being and to report on their vulnerability. The events of September 11, 2001 greatly heightened the importance of protecting the physical and cyber-based systems essential to the minimum operations of the economy and the government. However, reviews at contractors, grantees, HHS Agencies, and States continue to disclose significant impediments to the creation of an effective security program. HHS also faces the additional challenge of ensuring the privacy of medical records in electronic systems and transmissions, as required by HIPAA of 1996, effective April 14, 2003.

Assessment of Progress in Addressing the Challenge:

HHS has made progress in securing the most critical of essential assets, both physical and cyber-based, such as Department laboratories, computer systems, and data communication networks. Core requirements for security controls were established and distributed, and systems architecture documents are being developed. However, recent OIG assessments found numerous control weaknesses in entitywide security; access controls; service continuity; application security, development, and program change control; and segregation of duties. A collective assessment of deficiencies in Medicare systems resulted in the reporting of a material weakness in the FY 2003 HHS financial statement audit. Although the OIG has not found any evidence that these weaknesses have been exploited, they leave HHS vulnerable to unauthorized access to and disclosure of sensitive information, malicious changes that could interrupt data processing or destroy data files, improper payments, or disruption of critical operations. The OIG's FY 2004 FISMA reviews identified a significant deficiency for contingency planning.

While continuing to assess Medicare and Medicaid systems controls, OIG reviews will place new emphasis on compliance with HIPAA privacy rules and on security plans as new systems are developed, such as the Unified Financial Management System (UFMS) and HIGLAS.

Management Response:

FDA:

Over the course of this past year, the FDA Information Technology (IT) program has undergone significant restructuring, in which all aspects of FDA IT have been reorganized under the Office of the Chief Information Officer (CIO), with full IT operations and budget responsibility residing with the FDA CIO. The resulting organization provides a structure that lends itself to better information security program management, the propagation of standards, and consistent processes across FDA IT. As this IT organization evolves over time, these processes will become a more disciplined approach in the day-to-day operations, application development, and strategic vision of FDA IT.

Recently, the FDA has worked in conjunction with HHS and the Department of Homeland Security to identify and validate those FDA IT assets that support nationally critical functions and services. This validation process identified several nationally critical assets which, if unavailable, would have an unacceptably debilitating impact on FDA's ability to efficiently and effectively promote and protect the public health. Additional review has helped FDA to identify critical dependencies and single points of failure in

system and business processing, to improve strategic and operational plans for ensuring mission accomplishment, to increase the security posture of those critical assets, and to integrate those nationally critical assets into the overall HHS and FDA business continuity and disaster recovery (DR) efforts.

The FDA understands the importance of having a robust DR capability and has taken a system-level approach to contingency planning and DR to date. Currently, system-specific contingency plans have been developed to provide guidance and procedures for restoring required functionality to damaged systems. The FDA Office of the CIO has formed a DR working group with the goal of developing an Agency-wide DR capability, focusing initially on nationally critical FDA systems and infrastructures, and expanding over time to all FDA mission critical assets. This DR working group is collaborating with the FDA Business Process planning group to identify prioritized mission-critical functions, and their supportive IT systems.

To ensure continued mission support in the event of a disaster, FDA is also seeking a secondary data processing facility for DR outside of the Washington, DC metropolitan area. Having such a capability provides needed assurance that FDA can continue timely support of its mission commitments, including its nationally critical and bioterrorism responsibilities. FDA has attempted, in previous years, to advance that capability by arranging for an alternate data processing facility. However, that acquisition has proven problematic because from a single Agency perspective acquiring the site and meeting logistic requirements remain prohibitively expensive. As a result, FDA has requested assistance from HHS' CIO in leveraging the combined buying power of the Department while still meeting specific Agency needs, as this makes the strongest and most effective business case for HHS and FDA.

NIH:

As a participant in the "Secure One HHS" IT security program, NIH has implemented several Agency initiatives to support its research mission and operating environment. Examples are provided below:

- Required risk assessments, security plans, certifications, and accreditations for all new systems before they are fully implemented. All security controls are reviewed prior to accreditation of a new NIH system.
- Completed certification and accreditation (C&A) for 100 percent of identified critical cyber-based infrastructure systems, and data center and data communication networks.
- Revised NIH Network Interconnection Security Agreement (ISA) and developed ISA templates for systems that share sensitive information. This agreement is required for non-NIH organizations connected to critical NIH network resources in order to ensure adequate IT security. The ISA requires external organizations to have IT security standards that meet or exceed HHS and NIH requirements.
- Deployed autoblocking feature to block signature attacks in real time to prevent massive port scans of NIH critical and noncritical infrastructure.
- Conducted vulnerability assessments including: semiannual scans (all vulnerabilities); monthly scans (most critical vulnerabilities); weekend scans (HTTP and FTP servers); special scans (specific/new vulnerabilities); and validation scans (to ensure remediation). Analyzed and summarized data.
- Initiated penetration testing program for most critical/sensitive systems at NIH.

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Appendix B – Net Costs of Key HHS Programs

For the Fiscal Years Ended September 30, 2004 and 2003

(in millions)

The following table presents the net costs of HHS' 50 largest programs (based on their FY 2004 net cost) for FY 2004 and FY 2003. This listing includes programs aggregated from the several hundred total HHS programs. The net cost information is extracted from HHS Agencies' consolidated statements of net cost for FY 2004 and FY 2003, and supplements the program identified in the Department's consolidated statement of net cost. The shaded programs below relate to the programs discussed in the "Performance Overview" section of the *Management Discussion and Analysis* and in the *Program Performance Report* section of this report.

HHS Program	HHS Net Cost ($)		Rank by ($)		Budget Function	HHS Component Responsible for Program
	FY 2004	FY 2003	FY 2004	FY 2003		
Medicare	269,748	250,074	1	1	Medicare	Centers for Medicare & Medicaid Services
Medicaid	177,060	161,721	2	2	Health	Centers for Medicare & Medicaid Services
Research Program	25,748	23,057	3	3	Health	National Institutes of Health
Temporary Assistance to Needy Families	17,798	19,348	4	4	Education, Training & Social Services / Income Security	Administration for Children and Families
Child Welfare	7,193	6,952	5	5	Education, Training & Social Services / Income Security	Administration for Children and Families
Head Start	6,750	6,780	6	6	Education, Training & Social Services / Income Security	Administration for Children and Families
Child Care	4,863	5,089	7	7	Education, Training & Social Services / Income Security	Administration for Children and Families
SCHIP	4,611	4,360	8	8	Health	Centers for Medicare & Medicaid Services
Child Support Enforcement	3,971	4,060	9	9	Education, Training & Social Services / Income Security	Administration for Children and Families
HIV/AIDS Programs	2,130	1,981	10	11	Health	Health Resources and Services Administration
Primary Care (Note 1)	2,115	1,862	11	12	Health	Health Resources and Services Administration
Low-Income Home Energy Assistance	1,895	2,030	12	10	Education, Training & Social Services / Income Security	Administration for Children and Families
Social Services Block Grant	1,753	1,741	13	13	Education, Training & Social Services / Income Security	Administration for Children and Families
Clinical Services	1,681	1,591	14	16	Health	Indian Health Service
Public Health and Social Services [Note 2]	1,662	1,483	15	17	Health	Office of the Secretary
Substance Abuse Prevention & Treatment Block Grant	1,662	1,733	16	15	Health	Substance Abuse and Mental Health Services Administration
Immunization	1,570	1,734	17	14	Health	Centers for Disease Control & Prevention
HIV/AIDS, STD &TB Prevention	1,309	1,093	18	19	Health	Centers for Disease Control & Prevention
Community Based Services	1,239	1,225	19	18	Education, Training & Social Services	Administration on Aging
Maternal and Child Health	1,025	971	20	21	Health	Health Resources and Services Administration
Health Professions	906	1,066	21	20	Health	Health Resources and Services Administration
Chronic Disease Prevention	878	771	22	22	Health	Centers for Disease Control & Prevention
Community Services	761	727	23	23	Education, Training & Social Services / Income Security	Administration for Children and Families
PHS Commissioned Corps	627	558	24	24	Health	Program Support Center
Foods and Cosmetics	566	491	25	25	Health	Food and Drug Administration
Refugee Resettlement	508	449	26	28	Education, Training & Social Services / Income Security	Administration for Children and Families

HHS Program	HHS Net Cost ($)		Rank by ($)		Budget Function	HHS Component Responsible for Program
	FY 2004	FY 2003	FY 2004	FY 2003		
Contract Health Care	485	467	27	26	Health	Indian Health Service
Community Mental Health Services Block Grant	451	413	28	31	Health	Substance Abuse and Mental Health Services Administration
Program of Regional National Significances/Targeted Capacity Expansion (new)	423	313	29	33	Health	Substance Abuse and Mental Health Services Administration
General Departmental Management	402	435	30	29	Health	Office of the Secretary
Infectious Diseases	397	458	31	27	Health	Centers for Disease Control & Prevention
RNS Best Practices (Note 2)	367	367	32	32	Health	Substance Abuse and Mental Health Services Administration
Human Drugs	352	297	33	34	Health	Food and Drug Administration
Office of Special Programs	323	419	34	30	Health	Health Resources and Services Administration
Family Planning	283	261	35	36	Health	Health Resources and Services Administration
Tribal Activities: Contract Support	282	283	36	35	Health	Indian Health Service
Environmental Health	267	234	37	39	Health	Centers for Disease Control & Prevention
Medical Devices & Radiological Health	253	247	38	37	Health	Food and Drug Administration
Occupational Safety and Health	245	246	39	38	Health	Centers for Disease Control & Prevention
Hospitals-Facilities Support	219	198	40	41	Health	Indian Health Service
Sanitation Facilities	175	109	41	51	Health	Indian Health Service
Injury Prevention and Control	163	130	42	45	Health	Centers for Disease Control & Prevention
Developmental Disabilities	154	150	43	44	Education, Training & Social Services / Income Security	Administration for Children and Families
Public Health Improvement	140	120	44	50	Health	Centers for Disease Control & Prevention
Contributions, Indian Health Facilities	140	97	45	55	Health	Indian Health Service
Biologics	131	202	46	40	Health	Food and Drug Administration
Domestic Violence	120	125	47	48	Education, Training & Social Services / Income Security	Administration for Children and Families
Preventive Health & Health Services Block Grant	120	126	48	47	Health	Centers for Disease Control & Prevention
Animal Drugs and Feeds	120	124	49	49	Health	Food and Drug Administration
Youth	119	106	50	52	Education, Training & Social Services / Income Security / Admin of Justice	Administration for Children and Families
All Other HHS Programs	1,390	1,634			Various Components	Various Components
Total Net Costs (Note 3)	$ 547,550	$ 510,508				

Note 1. Includes the Foster Care/Adoptions program discussed in the *Management Discussion and Analysis* (Section I) and HHS *Program Performance Report* (Section II) of this report.

Note 2. Name of this program changed in FY 2004; was "Knowledge, Development and Application" in FY 2003.

Note 3. Total net costs agrees with Agency combined totals in the consolidating statement of net cost by budget function located in other accompanying information.

The shaded programs above relate to the programs discussed in the "Performance Overview" section of the *Management Discussion and Analysis* and in the HHS *Program Performance Report* section of this report.

Highlighted Programs (#)	16	16
Highlighted Programs ($)	$ 523,255	$ 486,220
Highlighted Programs (%)	95.56%	95.24%

Appendix C – Information on HHS Improper Payment and Recovery Auditing Initiatives

The Improper Payments Information Act of 2002 (IPIA) requires Federal agencies to review their programs and activities and identify those that may be susceptible to significant improper payments. Agencies are required to estimate the annual amount of improper payments and submit those estimates to Congress, along with actions taken to reduce improper payments, using a reporting method prescribed by the Office of Management and Budget (OMB). OMB Memorandum M-03-13, *Improper Payments Information Act of 2002 (P.L. No. 107-300)*, requires agencies to report the estimated amount of improper payments and progress in reducing them in the annual *Performance and Accountability Report* (*PAR*). The following section contains the required information in the format provided by OMB.

I. Describe your agency's risk assessment(s), performed subsequent to compiling your full program inventory. List the risk-susceptible programs (i.e., programs that have a significant risk of improper payments based on OMB guidance thresholds) identified through your risk assessments. Be sure to include the programs previously identified in the former Section 57 of OMB Circular A-11.

HHS developed an inventory of programs and a plan for prioritizing the completion of risk assessments for these programs. Risk assessments involved identification of specific program risks and assessment of related controls. Seven HHS programs were identified as high-risk programs in Circular A-11, Section 57 and HHS is in various stages of developing improper payment error rates or engaging in other initiatives to reduce improper payments in these programs. These seven programs include: Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), Child Care, Head Start, Foster Care, and Temporary Assistance for Needy Families (TANF). Of the programs where the risk for improper payments was assessed, none were determined to be at a high level of risk. To ensure that HHS risk conclusions are adequately and appropriately supported, HHS engaged the services of a contractor with experience in risk analysis to evaluate the Department's program risk assessment strategy and several FY 2004 program risk assessments. HHS will consider the contractor's work in completing the FY 2005 program risk assessments.

II. Describe the statistical sampling process conducted to estimate the improper payment rate for each program identified.

A. Medicare Fee-for-Service Program - HHS determined an improper payments estimate for Medicare Fee-for-Service (FFS). The Medicare FFS improper payment estimate is derived from two programs: the Comprehensive Error Rate Testing (CERT) program and the Hospital Payment Monitoring Program (HPMP). Each component represents about 50 percent of the erroneous payments. The CERT program calculates the error rate for Carriers, Durable Medical Equipment Regional Carriers, and non-Prospective Payment System (PPS) inpatient hospital claims submitted to Fiscal Intermediaries (FIs). The HPMP calculates the error rate for PPS inpatient hospital claims submitted to the FIs. The OIG-approved methodology includes:

- Randomly selecting about 160,000 claims;
- Requesting medical records from providers on these claims;
- Reviewing the claims and medical records for compliance with Medicare coverage, coding and billing rules; and
- Treating nonresponse by a provider as an error.

B. Medicaid Program – HHS determined payment accuracy rates for 12 States in a pilot project in the Medicaid program – the Payment Accuracy Measurement (PAM) pilot. Twelve States, representing 35 percent of total Medicaid expenditures, estimated their payment accuracy on a State-by-State basis. In the FFS component, States drew a proportional, stratified random sample of Medicaid claims across the major service categories. The review and audit consisted of processing validation and medical review. Six States also performed eligibility reviews. In the Managed Care component, processing reviews were performed in all States, eligibility reviews were performed in some States and medical reviews were performed in no States. Of the 12 States participating in FY 2003, 11 of these States determined FFS payment accuracy rates ranging from 81.4 percent to 99.7 percent, with 80 percent of the States having a payment accuracy rate over 95 percent; and five of these States determined Managed Care payment accuracy rates ranging from 97.5 percent to 100.0 percent, with 80 percent of the States having a payment accuracy rate over 99 percent.

C. SCHIP – HHS has plans in place to measure payment errors in SCHIP. In FY 2004, HHS expanded the Medicaid PAM pilot to include SCHIP. Fifteen States participating in the pilot will be calculating a payment accuracy rate for SCHIP. These rates will be reported in the FY 2005 PAR.

D. Child Care - HHS is working on plans to measure payment errors in the Child Care program. Because extensive State flexibility is permitted by the Child Care and Development Fund, defining error in a way that has meaning across the States has been difficult. This has presented challenges in identifying a cost efficient methodology for measuring improper payments in the Child Care program. Working toward identifying a methodology, HHS has initiated an improper payment pilot project to assess the efforts of several States to prevent and reduce improper payments in their Child Care programs. Eleven States are working with HHS in assessing the adequacy of State systems, databases, policy, and administrative structures to detect, prevent, and identify payment errors in Child Care programs. HHS has compiled the findings from these activities, assessed the different approaches the States use to track error rates, and documented effective procedures which can be used for technical assistance and also in developing a strategic plan to help grantees to reduce the rate of improper payments in the Child Care program. HHS will be using this information to expand the pilot project to include preparing a plan for measuring payment errors, and reporting on payment errors in the FY 2005 PAR.

E. Head Start – A payment error was defined as a payment for an enrolled child from a family whose income exceeds the allowable limit (in excess of the 10 percent program allowance for families above the income limit). Fifty Head Start programs were randomly selected and scheduled for federal monitoring reviews during the second half of FY 2004. Programs were selected using a stratified random sample, where programs were divided into five quintiles, and the number of programs sampled within each stratum was proportional to the number of children represented by each stratum. An appropriate sampling strategy was identified in order to determine the number of children's records to be pulled for each of the 50 selected grantees. Each program had to meet the requirement of 2.5 percent precision at a 90 percent confidence level. A payment error rate of 3.9 percent was computed for the Head Start program in FY 2004.

F. Foster Care - HHS has identified case errors in the Foster Care program using the eligibility review process promulgated in regulations at 45 CFR 1356.71(c). These reviews are conducted on-site, typically in the State capital where the child welfare central office is located. Under the regulatory process, primary

reviews are conducted in each State every three years by teams who review 80 cases selected from the State's Title IV-E foster care population using a simple random sample methodology or other probability sampling methodology. Under the review regulatory parameters, if the State has a less than 10 percent error rate (four error cases) on their primary review, the State is deemed to be in substantial compliance and a payment disallowance covering the entire period of ineligibility is assessed for each error case. For those States exceeding the 10 percent error rate, a secondary review is conducted. In the secondary review, 150 cases are selected for review from the State's Title IV-E foster care population using a simple random sample methodology, or other probability sampling methodology when necessary. The State is assessed an extrapolated disallowance equal to the lower limit of a 90 percent confidence interval for the State foster care population's total dollars in error during the 6-month period under review, if a State exceeds 10 percent for both case and dollar error rates. If the State does not exceed the 10 percent threshold, a payment disallowance covering the entire period of ineligibility is assessed for each error case. For the State's initial review (the first review under the regulation) the error rate threshold for substantial compliance was established at 15 percent. The results of the primary reviews conducted during the period May 1, 2003 to April 30, 2004 are as follows:

State	Cases in Error	Administrative Disallowance	Maintenance Disallowance
1	22	$113,144	$204,608
2	23	$107,458	$62,339
3	0	$0	$0
4	25	$38,878	$412,427
5	4	$5,049	$10,418
6	1	$4,107	$3,351
7	21	$29,195	$149,601

The maintenance disallowance pertains to the dollar value of improper payments associated with the cases in error, and the administrative disallowance pertains to the administrative cost of processing the cases in error.

G. TANF - The extensive flexibility of State TANF program operations and the prohibitions on data collection in the TANF legislation have been barriers in identifying an effective and cost efficient methodology for measuring improper payments in the TANF program. However, HHS has initiated various activities to explore possible methods for addressing payment errors and reducing the occurrence of improper payments in the TANF program. These activities serve to highlight the importance of proper payments and assist in efforts to reduce the occurrence of improper payments in the TANF program. These activities include:

- Soliciting information from States on "best practices" in identifying and reducing improper payments in the TANF program. States will be asked to voluntarily provide information on how they define improper payments; the process(es) used to identify such payments; and what actions are taken to reduce or eliminate improper payments. A repository for this information will be posted on an HHS/ACF website and will be available for viewing by all States.

- Conducting an improper payments demonstration project with a volunteer State in which the State would undergo a more in-depth review of TANF expenditures in the OMB Circular A-133, *Audits of*

States, Local Governments, and Non-Profit Organizations, audit process. The review results will be useful in assessing the potential rate of error in the TANF program in that State and in determining whether there is any value to expanding the project to other States in future years.

- Initiating various activities to improve data match capability and increase State utilization of the Public Assistance Reporting Information System (PARIS). The PARIS is a voluntary project that enables participating States' public assistance data to be matched against several databases to help maintain program integrity and detect and deter improper payments in several Federal programs.

III. Explain the corrective actions your agency plans to implement to reduce estimated rate of improper payments. Include in this discussion what is seen as the cause(s) of errors and the corresponding steps necessary to prevent future occurrences. If efforts are already underway, and/or have been ongoing for some length of time, it is appropriate to include that information in this section.

A. Medicare Fee-For-Service – Based on the FY 2003 findings, HHS identified and initiated appropriate corrective action during FY 2004, including:

- Increasing and refining one-on-one educational contacts with providers who are billing in error;
- Making it easier for providers to find Medicare rules by developing a website of national coverage, coding, and billing articles;
- Working on developing and installing new correct coding edits; and
- Treating non-response by a provider as an error.

A significant problem among the FY 2003 findings was a high non-response rate by providers. To reduce the non-response rate, HHS engaged in the following during FY 2004:

- Revising letters requesting medical records by clarifying the role of the CERT contractor, and that the requests do not violate HIPAA;
- Allowing for faxing of medical records;
- Requesting medical records in Spanish;
- Performing more intense follow-up on providers not providing records;
- Developing a website to track provider non-response;
- Referring provider non-responses on claims exceeding $40 to OIG; and
- Encouraging the use of Electronic Medical Record (EMR) submission pilots to facilitate process of submitting medical records.

Based on the FY 2004 findings, HHS has identified and will initiate the following corrective actions during 2005:

- Hiring an error rate documentation contractor whose primary focus will be lowering non-response and insufficient documentation rates;
- Conducting an insufficient documentation special study to better understand the causes of insufficient documentation;
- Releasing a List of Over-utilized Codes that show error rates and improper payments by contractor/by service;

- Opening a Los Angeles satellite office focused on identifying and preventing improper payments to providers in the Los Angeles area;
- Developing new data analysis procedures to help identify payment aberrancies and using that information in order to stop improper payments before they occur;
- Conducting a demonstration in three States to see if using recovery auditing contractors can help lower the error rates in these States by 1) improving provider compliance more quickly than States that don't have recovery auditing contractors, and 2) allowing regular contractors to spend fewer resources on post-payment review and focus more time and effort on prepayment review and education;
- Working with the American Medical Association (AMA) to clarify evaluation and management code documentation guidelines; and
- Considering contractor-specific error rates in the evaluation of contractors beginning in 2005.

B. Medicaid – HHS has worked closely with each State participating in the PAM pilot. Since the emphasis of the pilot is to work with each State in developing and implementing a methodology for estimating payment error rates in the Medicaid program for all States, corrective action is being addressed by each State based on its own experiences and PAM results. Once the PERM is implemented for all States, HHS will begin to analyze the results to identify what corrective action measures are necessary. However, because the Medicaid program is unique to each State, HHS expects that each State will identify and implement corrective action measures based on its own results.

HHS has also engaged in other activities. The Health Care Fraud and Abuse Control (HCFAC) account includes at least two projects (the hiring of 100 regional office positions to do prospective reviews of State Medicaid operations, and the Medicare/Medicaid data match program) designed to ferret out improper payments and identify areas in need of improved payment accuracy. OIG also continues to receive money from HCFAC to conduct audits on the Medicaid program. Further, the work being done in TANF to improve data match capability and increase state utilization of PARIS will benefit the Medicaid program, in affording States numerous opportunities to improve their payment accuracy, especially in the Managed Care portion of their programs.

C. SCHIP – The SCHIP payment accuracy rates to be determined in the third year of the PAM pilot will be reported in the FY 2005 *PAR*. Since the emphasis of the pilot is to work with each State in developing and implementing a methodology for estimating payment error rates in SCHIP for all States, corrective action is being addressed by each State based on its own experiences and PAM results. Once the PERM is implemented for all States, HHS will begin to analyze the pilot results to identify what corrective action measures are necessary. However, because the SCHIP program is unique to each State, HHS expects that each State will identify and implement corrective action measures based on its own results.

D. Child Care – Valuable information has been gained from the site visits and the ongoing communications with States in the improper payment pilot work. Because the causes of improper payments vary across States, it is difficult to identify a common theme for the causes of improper payments. However, States identified a number of reasons for improper payments:

- Balancing program integrity and accountability with providing services to children and families;
- Lack of technology to track and identify errors;
- Inability to verify changes in work and income between eligibility re-determination;
- Policies and practices that do not always meet the needs of working families;
- Lack of administrative controls that address contract billing and verification; and

- Lack of preventive, up front training for staff, providers and parents.

HHS will continue to meet with its partner States to gather information on States' experiences and methods of dealing with improper payments, best practices, and effective training materials. This information will be compiled and shared widely with States to support and promote peer-to-peer technical assistance. HHS will continue to provide policy clarification and guidance as needed.

E. Head Start – HHS plans several actions to reduce the estimated rate of improper payments (the enrollment of children who are not eligible for Head Start because their families do not meet income or other eligibility requirements) in the Head Start program. To improve recruiting and enrollment practices, an Information Memorandum is being sent to all programs reiterating the need to adhere to 45 CFR 1305, "Eligibility, Recruitment, Selection, Enrollment and Attendance in Head Start." The FY 2005 program monitoring reviews will increase attention to recruitment, enrollment, and eligibility issues. Additional training will be provided to the reviewers on how to consistently assess grantee recruitment, enrollment, and record-keeping practices.

F. Foster Care – States determined not to be in substantial compliance are required to develop a Program Improvement Plan (PIP) designed to correct the areas of noncompliance and to strengthen State programs. The PIP must identify the action steps to be taken by the State to correct deficiencies identified by the review team and each action step must have a projected completion date which will not extend more than 1 year from the date the PIP is approved by HHS. HHS believes that the development and implementation of the PIP is the key to identifying the reasons why cases are in error and motivating States to correct situations causing errors. A second review of a substantially larger number of cases is equally vital to the effort, as it allows HHS to extrapolate the results to the universe of Foster Care cases in the State during the 6-month period under review, resulting in a much larger disallowance. HHS expects that this approach will encourage States to improve their programs to the extent that when a secondary review is conducted they will be in substantial compliance.

An analysis of the final findings of States reviewed from FY 2000 to the present did not reveal systemic problems or trends. However, there were some general themes that emerged such as the use of inadequate or unacceptable language in court orders and the failure of the courts to make judicial determinations in accordance with required timeframes; the placement of children in unlicensed foster family homes or inadequate documentation of licensure in the case file; 100 percent charge of expenditures to Title IV-E rather than allocation to other benefiting programs; eligibility determinations and re-determinations without adequate supporting documentation; and automated payment system errors. A 1-year period to implement corrective action, along with available technical assistance resources, should be sufficient for States to comply with program requirements so that subsequent reviews will result in lower error rates.

G. TANF - Due to extensive flexibility of State TANF program operations and the prohibitions on data collection in the TANF legislation, HHS has not been able to identify an effective and cost efficient methodology for measuring improper payments in the TANF program. Considering these barriers, HHS is engaging in various activities for increasing program oversight and fiscal integrity in the TANF program. HHS will be assessing the results of these activities and determining if and what corrective action might be needed.

IV. Improper Payment (IP) Reduction Outlook FY 2005-2007

Program	FY 04 Outlays (in billions)	FY 04 IP %	FY 04 IP $	FY 05 %	FY 06 %	FY 07 %
Head Start	$6.555	3.9%	$255M	3.5%	3.1%	2.8%
Child Care	$4.832	Note 1				
Medicaid	$175.285	Note 2				
TANF	$17.725	Note 3				
Medicare	$213.500	10.1% Note 4	$21.7B	7.9%	6.9%	5.4%
Foster Care	$4.707	Note 5				
SCHIP	$4.607	Note 2				

Note 1 – See II.D above.
Note 2 – HHS determined payment accuracy rates in a PAM pilot for Medicaid. FFS payment accuracy rates for 11 States participating in the second year of the pilot ranged from 81.4 percent to 99.7 percent, with 80 percent of the States having a payment accuracy rate over 95 percent; Managed Care payment accuracy rates for five States participating in the second year of the pilot ranged from 97.5 percent to 100 percent, with 80 percent of the States having a payment accuracy over 99 percent. Fifteen States will be determining payment accuracy measurements for SCHIP in the third year of PAM pilot. In FY 2005, HHS will move to the PERM pilot. Thirty-two States will participate in FY 2005, and it is expected that all States will be participating in FY 2006. Due to the variances in the PAM and PERM methodologies, HHS will be using the results from the first year of the PERM pilot as a baseline. This will be reported in the FY 2006 *PAR*.
Note 3 – See II.G above.
Note 4 – Medicare FFS outlays are net offsetting receipts. 10.1 percent is the gross rate (over- and under-payments) for FY 2004; 9.3 percent is the net rate for FY 2004.
Note 5 – HHS expects to have a baseline for Foster Care in FY 2005.

V. Discussion of your Agency's recovery auditing effort, including the amount of recoveries expected, the actions taken to recover them, and the business process changes and internal controls instituted and/or strengthened to prevent further occurrences.

A contract to perform recovery auditing services at HHS was awarded in June 2004. During the months from July to September 2004, the contractor worked with several HHS payment offices to obtain electronic contract payment data files. The contractor will begin on-site recovery auditing in November FY 2005. It is expected that all HHS payment offices will be engaged in on-site recovery auditing activities by the second quarter of FY 2005. Other information is not available at this time since the recovery auditing program was only recently implemented at HHS.

VI. Describe the steps the agency has taken and plans to take (including time line) to ensure that agency managers (including the agency head) are held accountable for reducing and recovering improper payments.

The issuance of quarterly scorecard ratings for HHS Agencies has been a valuable tool for ensuring that Division Heads are held accountable for activities related to all IPIA activities. Further, during FY 2004, HHS issued a policy directive that requires that a new performance plan objective be included in performance plans in FY 2005. The objective requires that managers "identify and address weaknesses in grant systems(s), procurements system(s) and finance offices to ensure recovery of improper payments and to reduce the number of improper payments by the Department."

VII. A. Describe whether the agency has the information systems and other infrastructure it needs to reduce improper payments to the levels the agency has targeted. B. If the agency does not have such systems and infrastructure, describe the resources the agency requested in its FY 2005 budget submission to Congress to obtain the necessary information systems and infrastructure.

A. Medicare Fee-for-Service – HHS has the information systems and other infrastructure it needs to reduce improper Medicare FFS payments to the levels the Agency has targeted. HHS has several systems that contain information that allows it to identify developing and continuing aberrant billing patterns based upon a comparison of local payment rates with State and national rates. All the systems, both at the contractor level and at the central office level, are tied together by a high speed secure network that allows rapid transmission of large data sets between systems. Transmissions are made nightly and include all claims processed during the preceding day.

B. Medicaid – Currently, State participation in measuring improper payments in Medicaid is voluntary. HHS will not be able to determine its resource needs until the PERM is implemented nationwide. ("Notice of Proposed Rulemaking" for implementation of the PERM program in FY 2006 was published in the *Federal Register* in the fourth quarter of FY 2004). In addition, HHS requested funding in FY 2005 to enhance the effectiveness of the PARIS system, which identifies improper payments in the Medicaid program as well as other programs like TANF and Food Stamps.

C. SCHIP – Currently, State participation in measuring improper payments in SCHIP is voluntary. HHS will not be able to determine its resource needs until the PERM is implemented nationwide. ("Notice of Proposed Rulemaking" for implementation of the PERM program in FY 2006 was published in the *Federal Register* in the fourth quarter of FY 2004).

D. Child Care – The currently available mechanisms, such as State single audits and limited State data reporting, do not serve this purpose adequately. Resources are not available to conduct regular fiscal or program management reviews of grantees. However, the Improper Payment Pilot project that was started with funds designated in FY 2004 is still ongoing, and HHS continues to gather information and input from States on their policies and practices, as designated funds become available for site visits or coordination meetings. Some States have suggested that improved automation would assist them in controlling improper payments. For example, automated data matches with other State data sources can help to verify information provided by families and providers regarding their eligibility to participate in the Child Care subsidy program and regarding the level of child care services provided. Data runs could also help identify unusual circumstances or red flags that indicate possible error or fraud. HHS hosted a conference call with the State Child Care Administrators to discuss the feasibility of expanding PARIS to Child Care. HHS will continue to explore issues related to the use and participation in PARIS for the Child Care program, including cost-effectiveness. As viable measures are identified, action will be taken to address the related funding needs.

E. Head Start – Corrective action can be carried out with existing systems and resources. Many of the steps grantees need to take to fix problems, such as better record keeping, should be relatively easy to put in place. Increased HHS monitoring and enforcement activities will build on systems already in place.

F. Foster Care – The Adoption and Foster Care Analysis and Reporting System (AFCARS) is currently being used for the regulatory reviews. The sample of cases to be examined for the review is drawn from

AFCARS data that are transmitted by the State agency to the Administration for Children and Families (ACF) central office. The sample, drawn by ACF statistical staff, consists of cases of individual children who received at least one Title IV-E foster care maintenance payment during the 6-month reporting period reflected in the State's most recent AFCARS data submission. The "period under review" for the on-site review will coincide with the AFCARS reporting. Federal regulations at 45 CFR 1355.40 set forth the AFCARS requirements for the collection of uniform, reliable information on children in public foster care and children adopted under the auspices of the State's public child welfare agency. Utilizing this existing source of data reduces the burden on States to draw their own samples, promotes uniformity in sample selection, and employs the AFCARS database in a practical and beneficial manner. HHS is working with a contractor to develop a methodology that complements the current review process. Once a methodology has been approved, action will be taken contingent upon the availability of funds requested in the FY 2005 budget.

G. TANF – TANF legislation imposes limitations related to collecting and reporting information from States and provides States flexibility in operating their program operations. This presents challenges in identifying and implementing cost effective and efficient methods for estimating improper payments in the program. HHS has identified PARIS as an effective system for detecting and deterring improper payments. HHS requested funding in FY 2005 to enhance the effectiveness of PARIS in identifying improper payments in the TANF program as well as other programs like Medicaid and Food Stamps. How much HHS will be able to achieve for PARIS is dependent on obtaining appropriations designated for PARIS, including funding for a full-time equivalent position that will be devoted exclusively to managing/coordinating the PARIS activities.

VIII. A description of any statutory or regulatory barriers that may limit the agencies' corrective actions in reducing improper payments.

A. Medicare Fee-for-Service – No statutory or regulatory barriers have been identified.

B. Medicaid – As the Medicaid and SCHIP programs are administered by the States, the ability of HHS to obtain State compliance is limited in the absence of statutory authority to hold States accountable for meeting targets for the reduction and recovery of improper payments.

C. SCHIP – As the Medicaid and SCHIP programs are administered by the States, the ability of HHS to obtain State compliance is limited in the absence of statutory authority to hold States accountable for meeting targets for the reduction and recovery of improper payments.

D. Child Care – States are asking for special funding to encourage them to engage in improper payments work, whether it is additional targeted grant funds or a scheme that permits States to retain some portion of recovered funds. HHS has not analyzed these proposals in depth, but such an analysis could be possible next year after the cost/benefit work described above has been completed.

E. Head Start – There are no statutory or regulatory barriers that will prevent HHS from implementing appropriate corrective action to address identified causes for improper payments in the Head Start program.

F. Foster Care – Any change to sample size, the extrapolation of a disallowance following the primary review, or the current corrective action process, would not conform to current regulations. Any proposed changes in the compliance framework would need to be made available for public comment through the rulemaking process and a final rule published prior to implementation.

G. TANF – HHS is constrained by the following statutory provision: "SEC. 417. [42 U.S.C. 617] No officer or employee of the Federal Government may regulate the conduct of States under this part or enforce any provision of this part, except to the extent expressly provided in this part." There is no specific authority in the statute that would allow us to regulate in the area of improper payments.

IX. Additional comments, if any, on overall agency efforts, specific programs, best practices, or common challenges identified, as a result of IPIA implementation.

HHS has been a leader in the area of monitoring and mitigating improper payments in the Medicare FFS program. In FY 1996, the HHS OIG began estimating improper payments in the Medicare FFS program. In FY 2002, CMS took over the work and under a new error rate measurement methodology, the CERT, improved on the process and is now obtaining more detailed management information. This includes improper payment rates by contractor, by provider type, and by benefit service. This new level of detail has been extremely valuable in identifying the causes for improper payments and for developing and implementing appropriate corrective action. In its work in the Medicare FFS program, one of the greatest challenges for HHS is producing timely error rates. To that end, HHS is working to develop a more comprehensive and secure means of transferring confidential information to and from its contractors, providers, and other partners.

The Medicare FFS program is a Federally-administered program where most coverage and coding policies are developed by each local Medicare contractor and vary from contractor to contractor. As part of its preparations for the CERT program, HHS realized that it was critical to get all the local Medicare policies into a centralized web-based application. The Medicare Coverage Database (www.cms.hhs.gov/mcd) proved to be a valuable tool to allow the measurement of improper payments in a program where the rules varied from place to place. Although HHS was able to more readily address policy variances in the Medicare FFS program, it has proved to be more challenging in other HHS programs. For block grant programs, such as TANF and Child Care, where program legislation allows States maximum flexibility in operating their programs, the resulting diversity in State program operations has presented challenges in developing effective and cost efficient approaches for estimating improper payments in these programs. Further, some program legislation contains prohibitions on the information that can be requested from States, adding to this challenge.

In FY 2005, HHS will continue to work with its OIG and the OMB to explore possible effective and cost efficient approaches for identifying and reducing improper payments in these programs. HHS will also continue to provide leadership in the Improper Payment work groups under the Chief Financial Officers/ President's Council on Integrity and Efficiency Erroneous and Improper Payments working group. This forum has resulted in valuable Federal-wide discussion on the successes and challenges, such as those related to the Medicare, Child Care and TANF programs, of implementing the IPIA and other President's Management Agenda initiatives to reduce improper payments in Federal programs. HHS will continue to consider the experiences of other Federal agencies with similar programs and also explore Federal-wide initiatives for estimating and reducing improper payments.

Appendix D – FY 2004 Federal Managers' Financial Integrity Act Report on Systems and Controls

The Federal Managers' Financial Integrity Act (FMFIA) requires agencies to provide an annual statement of assurance on the effectiveness of their management, administrative, and accounting controls (Section 2 of the Act), and financial management systems (Section 4 of the Act). Significant deficiencies in internal controls are considered material weaknesses; significant deficiencies in financial management systems are considered material nonconformances. The full text of the Secretary's assurance statement for FY 2004 can be found in the Secretary's Letter at the beginning of this report; the Sections 2 and 4 results are discussed in the following pages. At the end of FY 2004, the Secretary reported three material weaknesses and one material nonconformance.

FMFIA Section 2 Material Weakness and Section 4 Nonconformances Outstanding

	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004
Section 2 Material Weaknesses Outstanding					
From Prior Year	5	5	2	1	0
New	0	0	0	0	3
Corrected/Reclassified	0	3*	1	1**	0
Outstanding as of 9/30/2004					3
Section 4 Material Nonconformances Outstanding					
From Prior Year	0	0	1	1	1
New	0	1*	0	0	0
Corrected/Reclassified	0	0	0	0	0
Outstanding as of 9/30/2004					1

* Financial Systems and Processes (HHS-00-01). This single Section 4 finding reflects HHS' action during FY 2001 to combine the following three Section 2 material weakness findings into a single finding, and reclassify the combined finding as a Section 4 non-conformance items (details and status in chart below):

- Financial Systems and Processes (HHS-00-01) (1a below)
- Financial Systems Analysis and Oversight (CMS 01-01) including Managed Care (1b below)
- Medicare EDP Controls (CMS 01-02) (1c below)

** "Deficiency in the Enforcement Program for Imported Foods" (FDA 89-02). Due to substantial FDA efforts, HHS no longer considers FDA 89-02 to be material at the department-wide level FDA continues to report this material weakness in its FMFIA report with a targeted correction date of FY 2005.

Status of Outstanding FMFIA Material Weaknesses or Nonconformances

#	Title & Identification Code	First FY Reported	Target Correction Date
Section 2			
	FISMA significant deficiency ID: HHS-04-01	FY 2004	End of FY 2005
	Departmental Payroll System ID: HHS-04-02	FY 2004	End of FY 2005
	Departmental Financial Reporting ID: HHS-04-03	FY 2004	FY 2005
Section 4			
1a	Financial Systems & Processes ID: HHS 00-01	FY 2001	UFMS FMFIA and FFMIA compliance (FY 2006) UFMS full implementation (FY 2007)
1b	CMS Financial Systems Analysis and Oversight (Including Medicare Accounts Receivable and Managed Care) ID: CMS 01-02 (formerly HCFA 97-02)	FY 2001	HIGLAS FFMIA compliance (FY 2006) HIGLAS full implementation (FY 2007)
1c	Medicare EDP Controls, including Application Controls for Medicare Contractors ID: CMS 01-02 (formerly HCFA 98-01a)	FY 2001	FY 2006 (Previously reported as FY 2004 in FY 2003 report)

Section 2 Material Weaknesses

HHS reports three new Section 2 material weaknesses: 1) FISMA significant deficiency; 2) Departmental Payroll System , and 3) Departmental Financial Reporting.

Federal Information Systems Management Act (FISMA) Significant Deficiency (HHS-04-01)

In the Department's FY 2004 FISMA report to the Office of Management and Budget (OMB), dated October 6, 2004, the OIG executive overview identified one "significant deficiency" at the Department level:

"Our FY 2004 FISMA evaluation determined that the Department has a significant deficiency in its information system security program relating to contingency planning and disaster recovery. Our evaluation identified weaknesses in these areas at 11 of 13 HHS Agencies. For 6 HHS Agencies this was a repeat finding from a previous FISMA evaluation. "

Per OMB FY 2004 guidance, a significant deficiency under FISMA is to be reported as an FMFIA material weakness under Section 2. HHS believes that although contingency planning and disaster recovery need to be addressed, this significant deficiency has little impact on day-to-day processing. According to the HHS Chief Information Officer, this finding is not a statement that some particular system has been compromised, although the FISMA report notes a few areas of improvement and contains a list of things HHS needs to do better. OIG also reported that another component of the deficiency is the Medicare EDP controls, which has already been identified through the Chief Financial Officer (CFO) audit process. This is a repeat finding and is addressed separately as part of the one Section 4 material nonconformance discussed below.

The FISMA report contains a corrective action plan to address these findings and includes a target date of September 30, 2005 for completing corrective action. However, due to FISMA confidentiality requirements, FISMA report findings are not published and therefore a detailed corrective action plan is not included in this published FMFIA report.

Departmental Payroll System (HHS-04-02)

The auditors found that there are significant deficiencies in the Departmental Payroll System that could result in misstatements to payroll-account balances and the Commission Corp liability, improper payments, release of sensitive data, and reduced controls over safeguarding of assets.

The Department is committed to putting any necessary remedial or preventive mechanisms in place to improve our audit standing. However, there are some areas where reasonable explanations were provided to findings and these areas may not change. We fully embrace having solid oversight responsibilities for payroll and personnel and have already implemented procedures and processes that address many of the concerns discovered during our massive data cleanup efforts. We believe that our efforts in the HR consolidation, implementing Department wide automated HR systems, and the transition to the Defense Finance and Accounting Service scheduled for March 2005 will enhance our ability to have a solid payroll system.

Departmental Financial Reporting (HHS-04-03)

The auditors found that the department lacks a coordinated process among cross-functional teams of finance, operations and legal personnel to monitor business activities to identify situations where accounting evaluation or decision-making may be necessary. The issue that gave rise to this problem is that HHS had a significant policy issue at the end of FY '04 that had a material impact on its financial statements. This issue was below the materiality threshold in prior years.

In response to the auditor's findings, HHS is taking the following actions. HHS will: (1) appoint a single point of contact (POC) within the HHS CFO's office responsible for early identification and resolution of significant policy issues that have an impact on HHS financial statements; (2) strengthen its existing CFO Quarterly Meetings with OPDIV CFOs at the Department level to ensure coordination among cross-functional teams of finance, operations, and legal personnel to identify significant programmatic activities that may impact the quarterly and annual financial statements; (3) hold OPDIV CFOs accountable for ensuring that programmatic and related legal issues are promptly identified and communicated to the HHS CFO POC; and 4) engage the active participation of OMB officials in the resolution of any significant policy issues.

Section 4 Material Nonconformance

At the end of FY 2004, HHS reported one Section 4 nonconformance, Financial Systems and Processes (HHS 00-01). This finding comprised three component findings: the Department-wide audit finding, and the two separate audit findings at the Centers for Medicare & Medicaid Services (CMS) -- Financial Systems Analysis and Oversight (CMS 01-01) and Medicare EDP [electronic data processing] Controls (CMS 01-02). Implementation of the Unified Financial Management System (UFMS) will provide the long-term solution to these problems and eliminate the Section 4 nonconformance by the end of FY 2006. As part of the Financial Analysis and Oversight component finding the auditors also determined that internal controls over the Managed Care program need to be improved. The auditors disclosed that there was a lack of and/or inconsistent documentation to evidence the on-going monitoring and oversight reviews of the Managed Care program.

HHS auditors have cited the Department's lack of an integrated accounting system as a material weakness and a specific impediment in preparing timely financial reports and statements. As part of Secretary Thompson's "One HHS" approach to managing the Department, HHS is developing and implementing an integrated UFMS to provide for Department-wide financial reporting. UFMS will generate interim and annual financial statements, as well as other required external and internal financial reports. UFMS consists of two primary components: the Health Care Integrated General Ledger System (HIGLAS), dedicated to CMS, and the second dedicated to the rest of HHS. FY 2005 will see a significant achievement for the UFMS effort. By the end of the year the system will be deployed at the Centers for Disease Control and Prevention (CDC) and the Food and Drug Administration (FDA). The National Institutes of Health (NIH) Business and Research Support System (NBRSS) has already been "stood up" and the HIGLAS will have been deployed at eight of the largest CMS Medicare contractors. This level of deployment will not comply with the requirements of the Federal Financial Management Improvement Act (FFMIA). The Department will not meet this level of materiality of financial operations until the end of FY 2006.

In the short term, HHS Agencies have continued to make substantial progress in addressing account analysis and reconciliation problems that contribute to the Department's FMFIA Section 4 nonconformance.

- NIH has implemented numerous additional analyses and reconciliations; a new, more disciplined and controlled process to prepare the trial balances from which NIH financial statements are prepared; and has identified additional areas of potential improvement on which NIH has already begun work. Also, NIH plans to validate or change certain internal processes and provide significant training to staff. This effort will result in benefits to accounting operations and to the administrative operations of Institutes and Centers. The Office of Financial Management, working with the NIH Center for Information Technology, has implemented a new web-based tool that allows staff to analyze all general ledger accounts individually and by transaction codes online. This has allowed NIH to correct and compensate for some of the deficiencies noted by auditors. The information is more reliable and available in a timely manner for review and reporting.

- CDC conducts periodic reviews, as well as monthly and quarterly reconciliations. CDC created the trial balance and financial statements offline using a manually-intensive process, which required excessive resources and increased the chance of error. The new UFMS will eliminate this material weakness by generating financial statements without the manually-intensive process.

- Auditors reported in their FY 2004 CMS audit report that, overall, the Medicare contractors continue to significantly improve the maintenance of supporting records for financial activities and year end balances. However, the lack of an integrated financial management system continues to impair CMS and its Medicare contractors' abilities to efficiently and effectively support and analyze accounts receivable and other reported financial balances on a timely basis. The CMS long-range plan to address this material weakness is to implement, including Medicare contractors, a Joint Financial Management Improvement Program-approved integrated general ledger accounting software package.

- Managed Care Program -- CMS central office has revised its Standard Operating Procedures (SOP) regarding the Managed Care program and has posted the SOP on the Intranet. The *Preferred Provider Organization Demonstration Guid*e was completed June 2004, and the *Health Care Pre-payment Plans Guide* was revised and completed in June 2004. The attestation module in the Health Plan Management System has been completed and is operational.

CMS also continues to make substantial progress on mitigating the EDP control weaknesses and has revised its target for completing the related corrective action to FY 2006. CMS reports that the material weakness for the Medicare EDP controls is very complex involving approximately 33 contracts with the fiscal intermediaries and carriers who process claims using 16 data centers. Because of this complexity, resolution of the material weakness will take time and resources. The long-term strategy in eliminating the material weakness is rooted in the CMS modernization initiative that will further improve HHS' security posture. The President's budget for FY 2005 includes funding for information technology modernization. A more secure system environment is a key component of the IT modernization plan. CMS is implementing its plan using a two-track policy for security. On the first track, CMS is aggressively taking reasonable and appropriate remedial steps to close the highest risk vulnerabilities. These actions are reflected in HHS' Plan of Action and Milestones (POA&M) report. On the second complementary track, CMS is building security into the agency's modernized infrastructure through capital investments targeted to reduce its security perimeter. CMS will limit its exposure to risk through such preemptive measures as data center consolidation and simplifying application development in a way that leaves less opportunity for exploitation

than is the case in the current highly complex systems environment. To reinforce this further, CMS' Information Services Modernization Implementation Strategy includes security components for application modernization, data modernization, and infrastructure modernization. The CMS' main effort is on building a secure infrastructure versus managing corrective actions. CMS intends to be proactive in managing IT modernization and will address all audit results as part of the POA&M report process.

The following tables provide corrective action plans for the following:

- Departmental Payroll System (material weakness);
- Departmental Financial Reporting (material weakness); and
- Financial Systems and Processes, a material nonconformance, which includes three sub-components:
    - Departmentwide (HHS-00-01),
    - CMS Finanical Systems Analysis and Oversight (CMS 01-02), and
    - Medicare Information System Controls (CMS 01-02)

Section 2 Material Weakness
HHS 04-02 Departmental Payroll System

Background

This material weakness was first identified in FY 2004.
The Department's Payroll System internal controls need strengthening. The auditor's findings included some errors in pay, annual and sick leave balances, FEGLI withholding and insufficient or incorrect supporting documentation.

Summary of Corrective Action Approach: HHS has made significant changes to its human resources operation in response to the President's Management Agenda (PMA). It was one of the first agencies to embrace the e-Gov e-Payroll initiative to consolidate to four payroll providers. As part of this initiative, in FY 2001, HHS established a goal of consolidating its human resources services activities. Beginning in FY 2002, several of our Operating Divisions internally consolidated their human resources function to a single office. The final step in the consolidation took place in January 2004, when we established the Human Resources Centers (HRCs). The recent implementation of this consolidation was designed to consolidate more than 40 decentralized HR offices into 4 HR service centers. This initiative has helped us recognize the need for improvement in our HR operations to include more training, periodic review of how our systems interface, and establishment of consistent processes and policies across the Department.

As we move forward in these areas, our human resources staff are also devoting an enormous amount of time to other efforts. For example, of primary concern is the transition of payroll services to the Defense Finance and Accounting Service (DFAS), which is scheduled for March 2005. Additionally, the Electronic Official Personnel Folders (eOPF) project is scheduled for implementation from December 2004 - September 2005.

These initiatives (i.e., HR consolidation, transition to DFAS, and migration to the eOPF) have focused our attention on several issues we need to address before the transition to DFAS and eOPF. We are also committed to putting any necessary remedial or preventive mechanisms in place to improve our audit standing. However, there are some areas where reasonable explanations were provided to findings and these areas may not change. We fully embrace having solid oversight responsibilities for payroll and personnel and have already implemented procedures and processes that address many of the concerns discovered during our massive data cleanup efforts. We believe that our efforts in the HR consolidation, implementing Department wide automated HR systems, and the DFAS transition will enhance our ability to have a solid payroll system.

Target Correction Date: FY 2005 - We believe the HR consolidation, implementation of the e-OPF and transition to the DFAS are providing the Department with opportunities to comply with the FMFIA by the end of FY 2005.

Key Milestones for Corrective Action

Completed Corrective Actions:

- Organized and planned for e-Payroll transition. *May 2003*
- Analyzed and built Phase1 and 2 for e-Payroll transition. *October 2004*
- Established Human Resources Workgroup to identify requirements, prioritize enhancement requests, participate in testing EHRP changes, and serve as conduit for information on HR, e-Payroll. *August 2004*
- Established an accountability and technology initiative to ensure communications and teamwork. *August 2004*
- Trained human resources staff (i.e., timekeepers, payroll liaisons, ITAS representatives, etc.) to prepare for expected move to DFAS. *August 2004*
- Reissued documentation on appropriate Commissioned Corps survivor benefit procedures. *December 2004*

FY 2005 Planned Actions:

- Continue to present to the IT Investment Review Board (ITIRB) all changes to the HR systems. *December 2004 - September 2005*
- Test and prepare for e-Payroll transition to DFAS. *March 2005*
- Cleanup and validate personnel files; and test and prepare for the migration to the eOPF: implementation. *December 2004 - September 2005*
- Provide training and/or distribute guidelines on time and leave policy. *January - September 2005*
- Implement periodic checks for accuracy on civilian and Commissioned Corps actions. *FY 2005*
- Provide mini training sessions that target specific recurring types of errors (i.e., special pay, retention allowances, timekeeper, data entry, and systems, etc.). *January - September FY 2005*

Section 2 Material Weakness
HHS 04-03 Departmental Financial Reporting

Background

This material weakness was first identified in FY 2004.
Accelerated government-wide financial reporting requirements include the fact that policy decisions that have an impact on agency financial statements are to be resolved by Federal agencies timely to ensure that audited financial statements are issued timely and within federal requirements. In order to meet these requirements, HHS policy officials need to develop a more effective approach for the early identification and resolution of significant policy issues that have an impact on HHS financial statements. This approach should include coordination early and throughout the process with appropriate officials both within and outside HHS.

The issue that gave rise to this problem is that HHS had a significant policy issue at the end of FY '04 that had a material impact on its financial statements. This issue was below the materiality threshold in prior years. As a result, the HHS auditors found that the Department lacks a coordinated process among cross-functional teams of finance, operations, and legal personnel to monitor business activities and identify situations where accounting evaluation or decision-making may be necessary; and that no structured process exists to communicate potential loss contingencies to legal or accounting personnel. Further, the auditors found that upon identification of potential loss contingencies, no rational, structured process exists to ensure timely resolution of accounting questions by appropriate personnel. This condition could also impact the ability to rely on financial reporting from other OPDIVs or HHS as a whole.

One of the auditor's recommendations is the establishment of appropriate polices, procedures and protocol, including clearly assigning responsibility, to address situations or transactions that require cross-functional involvement in determining accounting-related estimates. The financial management function should coordinate and facilitate the involvement of the other cross functional units whose input are important factors in formulating the amount of the estimate.

Target Correction Date: FY 2005

Summary of Corrective action Approach: HHS will: (1) appoint a single point of contact (POC) within the HHS CFO's office responsible for early identification and resolution of significant policy issues that have an impact on HHS financial statements; (2) strengthen its existing CFO Quarterly Meetings with OPDIV CFOs at the Department level to ensure coordination among cross-functional teams of finance, operations, and legal personnel to identify significant programmatic activities that may impact the quarterly and annual financial statements; (3) hold OPDIV CFOs accountable for ensuring that programmatic and related legal issues are promptly identified and communicated to the HHS CFO POC; and 4) engage the active participation of OMB officials in the resolution of any significant policy issues.

Key Milestones for Corrective Action

- Appoint a HHS CFO POC who will be responsible to develop an effective approach for the early identification and resolution of significant policy issues that have an impact on HHS financial statements. The approach will be approved by appropriate policy officials and clearly communicated to affected personnel. *December 2004*
- The HHS CFO POC will meet with OPDIV CFOs on lessons learned from the FY '04 audit. OPDIV CFOs will assess their current internal review processes for early identification of any issues with materiality and legal implications that could lead to significant financial statement adjustments including review of their OPDIV's FY '04 legal representation letters with legal staff as a baseline. Any such issues will be promptly communicated to the HHS CFO POC who will follow the established approach including notification and coordination within and outside HHS. *January 2005*
- Beginning with the first CFO quarterly meeting in CY '05, utilize individual CFO Quarterly meetings with OPDIV CFOs to reinforce to OPDIV CFOs their obligation to reach out to program directors and legal staff to identify early significant programmatic activities that may materially impact the quarterly and annual financial statements to promptly notify the HHS CFO POC, and to assist in timely resolution of all issues to meet financial reporting requirements. *February 2005 and quarterly, thereafter*
- Continue to hold financial statement assessment meetings with OPDIV CFOs to address significant issues that may impact the financial statement audit and reinforce and follow the approved approach. *At least quarterly*

Section 4 Material Nonconformance
HHS 00-01 Department-wide Financial Systems and Processes

Background

This Department-wide material nonconformance was first identified in FY 2000.

The Department continues to have serious internal control weaknesses in its financial systems and processes for producing financial statements. The FY 2003 CFO audit and the FMFIA Report reflected a material non-conformance Department-wide under the FFMIA, which was reclassified in FY 2001 under Section 4 of the FMFIA as Financial Systems and Processes (HHS-00-01). This finding combined the Department-wide audit finding with the audit findings at CMS. CMS' FY 2003 financial statements audit revealed the same two material weaknesses as in the FY 2002 audit, specifically: Financial Systems and Analysis (CMS-01-01) and Medicare EDP Controls (CMS 01-02). For NIH, the auditors concluded that NIH financial systems, including mixed systems, do not fully conform to all government-wide standards required by OMB Circular A-127, *Financial Management Systems*. For CDC, the FY 2003 audit reported that CDC's financial system did not have the capability to generate financial statements.

Target Correction Date: FY 2006 - FFMIA/FMFIA compliance for UFMS and HIGLAS (the largest Medicare contractors will be using HIGLAS). Implementation of UFMS in accordance with approved implementation plan will allow HHS to comply with the FFMIA/FMFIA by the end of FY 2006. OMB, as a result of its review of key UFMS planning documents and discussions with HHS officials, recognized in its quarterly progress reports for the President's Management Agenda (PMA) that the Department's current PMA financial management "status" could improve when the UFMS is substantially implemented at the end of FY 2006 and this nonconformance is resolved or downgraded to a reportable condition. In the short term, account analysis and reconciliations are helping to mitigate systems weaknesses. Full UFMS/HIGLAS implementation is expected in FY 2007.

Key Milestones for Corrective Action

FY 2004 Milestones:

- HIGLAS -- Delivered the capability to execute the claims payment processing cycle including inbound claim, payment generation with AR/AP netting, and outbound notification. Provided the business flow in the pilot contractor setting. *Completed October 2003*
- NIH/NBS -- Finance and accounting functionality go live with FY 2004 travel transactions being posted to the ORACLE sub-ledgers and flowing to the general ledger. *Completed October 2003*
- UFMS/Global -- Conducted CRP2 conference room pilots in CDC, Atlanta to validate: (1) that the system as configured can accommodate CDC's integrated business processes; (2) the integration of specific external systems using interface processes plus cross-module and cross-functional activities, not including data validation; and (3) specific global interfaces and extensions. *Completed March 23 through April 1, 2004*
- UFMS/Global -- Based on discussions with OMB, HHS submitted draft proposal to OMB regarding PMA criteria for "Accurate financial information on demand used for day-to-day management." *June 2004 (Draft proposal pending management and OMB review)*
- UFMS/Global -- Shared Services study was completed on schedule. Recommendations for a structure focused on continuous quality improvements were presented to the UFMS Planning and Development and Steering Committees and approval for implementation and/or further development was granted. *Completed May 2004*
- NIH/NBS System -- Continue and complete data conversion. *May 2004*
- HIGLAS -- Add history, deliver functionality for system and accounting audit ability, and summary/detail document level history. Also add the balance of functionality needed to complete the full business "footprint" of the claims payment process. *September 2004*

FY 2005 Milestones:

- CDC and FDA implement UFMS general ledger and payroll accounting activities. *October 2004*
- CDC to implement grant accounting. *First quarter*
- FDA and CDC to implement the full scope of UFMS. *April 2005*
- HIGLAS: Will implement at Medicare Part A pilot contractor in FY 2005
- HIGLAS: Will implement at Medicare Part B pilot contractor in FY 2005.
- HIGLAS: Roll-out Wave 1 will see 3 additional Medicare contractors transitioned through third quarter FY 2005. *June 2005*
- HIGLAS: Roll out Wave 2 will see 3 additional Medicare contractors transitioned. *September 2005*

Long-Term UFMS Milestones:

- NIH Business and Research Support System (NBRSS) - complete deployment. *FY 2007*
- UFMS and HIGLAS: FFMIA Compliance. *End of FY 2006*
- UFMS: Department-wide Full Implementation. *FY 2007*
- HIGLAS: Full Implementation. *FY 2007*

Material Nonconformance
CMS 01-01 CMS Financial Systems, Analysis and Oversight
This finding is a subset of the Section 4 Department-wide material nonconformance HHS 00-01

Background

First Year Identified: FY 1997

The financial statement auditors reported that CMS relies on a decentralized organization, complex and antiquated systems, and ad hoc reports to accumulate data for financial reporting due to the lack of an integrated accounting system at the Medicare contractor level. An integrated financial system and strong oversight are needed to ensure that periodic analyses and reconciliation are completed to detect errors in a timely manner. Also, improvement is called for in the oversight of the Managed Care program. The auditors disclosed that there was a lack of and/or inconsistent documentation to evidence the ongoing monitoring and oversight reviews of the Managed Care program. For the Medicaid and the State Children's Health Insurance Programs, the auditors also found that CMS needs to improve its communication processes and procedures to prevent financial statements from being issued that are materially misstated.

Target Correction Date: FY 2006 - FFMIA/FMFIA compliance for UFMS and HIGLAS (the largest Medicare contractors will be using HIGLAS). Implementation of UFMS in accordance with approved implementation plan will allow HHS to comply with FFMIA by the end of FY 2006.

Brief Description of Corrective Action Plan: While CMS has made significant improvements in financial reporting, the long-term solution to this material weakness is HIGLAS. Until this system is implemented, CMS will continue projects and activities aimed at compensating for the lack of the modernized system. Until this system can be fully implemented, CMS will continue to implement short-term corrective actions, as outlined in its CFO's *Comprehensive Plan for Financial Management*, to address this material weakness. The four key financial management objectives of this plan are to: (1) improve financial reporting, guidance, and oversight by providing timely, reliable, and accurate financial information that will enable CMS managers and other decision makers to make timely and accurate program and administrative decisions, (2) design and implement effective financial management systems that comply with FFMIA, (3) improve debt collection and internal accounting operations, and (4) validate key financial data to ensure its accuracy and reliability.

Managed Care Program: With regard to the oversight of the Managed Care program, the CMS central office staff will follow up with all regional offices to ensure that the regional offices follow the audit protocols for cost plans, demonstrations, and health care pre-payment plans, follow the Medicare+Choice/Medicare Advantage monitoring guide, and maintain adequate documentation to evidence these reviews. The Health Plan Management System used for management of the Managed Care program will be updated for changes in a timely manner.

Key Milestones for Corrective Action

FY 2005 Milestones:

- Acquire Statement of Accounting Standards (SAS) 70, *Service Organizations*, and agreed upon procedure services to validate receivable balances and other financial data. *April 2005*
- Provide annual financial management training, including analysis, to contractors. *July 2005*
- Complete SAS 70 internal control reviews. *August 2005*
- Revise financial management Internet manual. *September 2005*
- Complete agreed-upon procedure reviews. *September 2005*
- Establish corrective action plans from agreed-upon procedure reviews. *September 2005*
- Contractors to implement corrective action plans from reviews. *September 2005*
- Perform on-site reviews at a sample of contractors. *September 2005*
- Monitor the monthly CMS 1522 reconciliation submitted by contractors. *Monthly*
- Perform trend analysis on receivable balances reported. *Quarterly*
- Implement HIGLAS at selected Medicare contractor locations. *FY 2005*
- Complete HIGLAS implementation. *FY 2007*

<u>Managed Care:</u>

- Maintain Medicare Managed Care organization-related documents. *Ongoing*
- Update Health Plan Management System for any changes in a timely manner. *Ongoing*

<u>Medicaid:</u>

- Conduct quarterly meetings that include the Administrator, Deputy Administrator, Chief Operating Officer, Chief Actuary, CFO, and Chief Counsel, to ensure all financial statement issues (e.g., potential liabilities) are identified. *Quarterly*
- Increase regional office oversight of the Medicaid program. *Ongoing*

Material Nonconformance
CMS 01-02 Medicare EDP Controls
This finding is a subset of the Section 4 Department-wide material nonconformance HHS 00-01

Background

First Year Identified: FY 1998
The financial statement auditors reported that EDP control weaknesses at CMS central office and the Medicare contractors exist in the areas of entitywide security programs, logical and physical access controls, application security development and program change controls, systems software, and service continuity planning and testing. The majority of the weaknesses were noted at the Medicare contractors, rather than the CMS central office. Audit procedures disclosed no evidence of actual system compromise of security, but in the aggregate the weaknesses identified were considered material. The Department anticipates that this weakness will carry over into FY 2006.

Target Correction Date: FY 2006. The correction date reported in the FY 2003 *Performance and Accountability Report* was FY 2004. The reason for the change in date is that the CMS modernization is programmed to commence in FY 2004.

Brief Description of Corrective Action Plan: The CMS recognizes the significance of security measures regarding Medicare EDP issues as they relate to the integrity, confidentiality, and availability of sensitive Medicare data. CMS received funding in August 2002 to mitigate the most vulnerable weaknesses at the Medicare contractors and data centers. The distribution based on risk analysis was to fund system security plans for the contractor claims processing systems, access controls, systems software, segregation of duties, and service continuity. Funding decisions were risk-based and business-driven. Additional weaknesses were funded in FY 2004 through redistribution of funds remaining from the initial FY 2002 distribution. The full implementation of the modernization program will address issues contributing to the material weakness.

Primarily due to the large size and complexity of the Medicare Fee-for-Service claims processing system and number of data centers, the completion dates will extend into FY 2006. The sheer magnitude of the Medicare claims processing system, encompassing 16 data centers and 33 entities that process claims, coupled with the level of aggressive oversight, guarantees that there will always be findings. The issue is to keep these findings to a manageable number with no critical vulnerabilities.

It is important to note that funding has been requested and received for FY 2004 as part of the CMS Modernization initiative. Additional funding is requested for FY 2005. The CMS Modernization initiative is the long-term plan for addressing these security issues, e.g., by reducing the security perimeter through Medicare contractor reform and data center consolidation.

Key Milestones for Corrective Action

FY 2005 Milestones:

- Require Medicare contractors to use CMS systems security methodology to develop plans in the future as funding permits. *September 2005*
- Develop and implement consistent and effective physical and logical access procedures, including administration and monitoring of access by contractor personnel in the course of their job responsibilities. *September 2005*
- Provide guidance to contractors for computer security configuration settings. *Completed*
- Develop and implement consistent and effective application security, development and program change controls, e.g., to document and control the authorized use of system edits. *September 2005*
- Develop additional testing procedures for selected Medicare sites for application changes. *September 2005*
- Enhance system software settings/controls for network servers. *Completed*
- Develop and implement more consistent change control procedures for selected applications. *September 2005*
- Strengthen password controls for selected applications. *September 2005*
- Ensure service continuity planning and testing at both contractor sites and at the CMS central office. *September 2005*
- Implement security enhancements addressing the performance problem areas. *September 2006*
- In conjunction with the OIG, develop a strategy focusing on repeat findings, and based on the funding availability, take action to address the root causes of findings enterprise-wide. *September 2006*

Appendix E – FY 2004 Federal Financial Management Improvement Act Report on Compliance

Auditors of Executive Agencies' financial statements are required to report if the agencies' financial management systems are in substantial compliance with the requirements of the Federal Financial Management Improvement Act (FFMIA) of 1996. Such audits are to be conducted in accordance with OMB's revised FFMIA *Implementation Guidance*, dated January 4, 2001.

Under FFMIA, agencies also are required to report whether their financial management systems substantially comply with the Federal financial management systems requirements, applicable Federal accounting standards, and the United States Government Standard General Ledger (USSGL) at the transaction level.

Instances of Noncompliance

The Department's FY 2004 financial statement audit revealed two instances (see chart) in which HHS financial management systems did not substantially comply with Federal financial management systems requirements. HHS concurs with the auditor's findings.

To make the HHS general ledger USSGL-compliant, the Department has created an extension, based on the Common Accounting Number (CAN)-Budget Accounting Classification Structure (BACS) crosswalk, which will select the correct Treasury transaction codes. This extension will enforce rules and populate the correct values to make UFMS USSGL-compliant.

The FY 2004 audit recognized the significant steps taken by the Department to resolve material weaknesses found in previous years. The following is a summary of some of the corrective actions taken and the current status for each of the areas of noncompliance.

Instances of Noncompliance
Noncompliance Number 1: Financial Management Systems and Processes
• The financial management systems and processes used by HHS and its agencies made it difficult to prepare reliable and timely financial statements. The processes required extensive, time-consuming manual spreadsheets and adjustments to report accurate financial information; • At most HHS Agencies, suitable systems were not in place to adequately support sufficient reconciliation and analyses of significant fluctuations in account balances; and • CMS did not have an integrated accounting system to capture expenditures at the Medicare contractor level, and certain aspects of the financial reporting system did not conform to the requirements specified by the Joint Financial Management Improvement Program. CMS needed extensive consultant support to establish reliable accounts receivable balances.
Noncompliance Number 2: General and Application Controls
• General and application controls over the Medicare contractors' financial management systems, as well as systems of certain other HHS Agencies, were significant departures from requirements specified in OMB Circular A-127, *Financial Management Systems*, and OMB Circular A-130, *Management of Federal Information Resources*.
Noncompliance Number 3: Departmental Payroll System
• The Independent Service Auditor's Report for the Human Resource Service identified certain controls related to the Entity-wide security Program, logical and physical access, segregation of duties, authorization and completeness that were not operating effectively.

Corrective Actions

Financial Management Systems and Processes

The Department's long-term strategic plan to resolve this material weakness is to replace the existing accounting systems and certain other financial systems within the Department. The short-term focus has

been on improving the quality of the data in the accounting systems by increasing periodic reconciliation and analyses, and implementing a web-based Automated Financial System for collecting and consolidating financial statements Department-wide. Over the last several years HHS has continued to make progress in strengthening its financial management and has a plan to bring its FFMIA systems into compliance by replacing antiquated financial systems with the Unified Financial Management System. (UFMS)

FY 2004 Unified Financial Management System (UFMS) Accomplishments

- Began implementation at the Program Support Center (PSC).
- The Food and Drug Administration conducted successful conference room pilot.
- The Centers for Disease Control and Prevention (CDC) conducted mock conversions 1-4.
- CDC began end-user training.
- CDC conducted integration testing.
- PSC conducted conference room pilot.
- Travel module deployed at the National Institutes of Health (NIH) for HHS travelers.
- Implemented Oracle General Ledger and Federal Administrator at NIH.

A major subcomponent of UFMS is the CMS Healthcare Integrated General Ledger Accounting System (HIGLAS). The lack of an integrated financial management system continues to impair CMS' and the Medicare contractors' abilities to adequately support and analyze accounts receivable and other financial balances reported. CMS is implementing a comprehensive plan to bring its financial systems into compliance. Specifically, CMS has initiated steps to implement an integrated standard general ledger system, known as HIGLAS, for the Medicare contractors and regional and central offices. HIGLAS will initially integrate the CMS' financial systems with the Medicare contractors' two existing shared claims processing systems. The CMS' current mainframe-based financial system will also be replaced by HIGLAS, the foundation of which is a web-based, Joint Financial Management Improvement Program (JFMIP)-certified, commercial-off-the-shelf system. The CMS' current plans are that by the end of FY 2005, HIGLAS will have been deployed at eight of the largest CMS Medicare contractors. This level of deployment will not comply with the requirements of the FFMIA. The Department will not meet this level of materiality of financial operations until the end of FY 2006. Full implementation of HIGLAS is expected to be completed in FY 2007.

FY 2004 HIGLAS Accomplishments

- Established a CMS HIGLAS program office with a staff of 20 full-time equivalents. An FY 2002 action, the HIGLAS program office continues to exist.
- Continued implementation of an approved JFMIP commercial-off-the-shelf product at the two pilot sites.
- Completed the design and building of HIGLAS functional specifications/requirements for the two Medicare contractor pilot locations with continuous project planning, status updating, and monitoring.
- Conducted five technical requirement pilots in nine sessions. All activities completed in FY 2004.
- Established the Application Software Provider and technical infrastructure, and running 11 non-production instances of the Oracle software in a test environment. The provider transitioned from a PricewaterhouseCoopers contract with EDS to an IBM data center during FY 2004.
- Established the HIGLAS Change Control Board with support from the Technical Configuration Committee, Requirements Management Committee, and the Performance work group to ensure decisions are made accurately and timely. A FY 2002 activity, these groups continue to support HIGLAS.
- Established an Earned Value Management System that produces reports to assist project monitoring and control. Initially in FY 2002 and again in FY 2003 when IBM was awarded a new contract.
- Created a HIGLAS website at www.cms.hhs.gov/ to provide program status for project stakeholders. Initially created in FY 2002.

Following is an example of the Department's FY 2004 achievements:

- CMS continues to provide instructions and guidance to the Medicare contractors and its central and regional offices. It continues to contract with independent public accountants to test financial management internal controls and to analyze accounts receivable at Medicare contractors. CMS created work groups comprised of central and regional office consortia staff to

serve as subject matter experts responsible for addressing four key areas: (1) follow up on the corrective action plans; (2) reconciliation of funds expended to paid claims; (3) trend analysis; and (4) internal controls. As CMS progresses toward its long-term goal of developing an integrated general ledger system, it continues to provide training to the contractors to promote a uniform method of reporting and accounting for accounts receivable and related financial data. CMS also completed automated applications for preparing all five required principal financial statements.

General and Application Controls

The CMS recognizes the significance of security measures regarding Medicare EDP issues as they relate to the integrity, confidentiality, and availability of sensitive Medicare data. The CMS received funding in August 2002 to mitigate vulnerable weaknesses at the Medicare contractors and data centers. The distribution based on a risk analysis was to fund system security plans for the contractor claims processing systems, access controls, systems software, segregation of duties, and service continuity. Funding decisions were risk-based and business driven. Additional weaknesses were funded in FY 2004 through redistribution of funds remaining from the initial FY 2002 distribution. The full implementation of the modernization program will address issues contributing to the material weakness.

Primarily due to the large size and complexity of the Medicare Fee-for-Service claims processing system and number of data centers, the completion dates will extend into 2006. The FY 2004 report will be issued in November 2004. The sheer magnitude of the Medicare claims processing system, encompassing 16 data centers and 33 entities that process claims, coupled with the level of aggressive oversight guarantees that there will always be findings. The issue is to keep these to a manageable number with no critical vulnerabilities.

It is important that funding has been requested and received for FY 2004 as part of the CMS Modernization initiative. Additional funding is requested for FY 2005. The CMS Modernization initiative is the long-term plan for addressing these security issues, e.g., by reducing the security perimeter through Medicare contractor reform and data center consolidation.

The CMS strategy is to make investments in the short run to create a more secure systems environment where security platforms have been upgraded and integrated, e.g., robust firewalls, intrusion detection, authentication, etc., but not to expend all available resources on addressing individual audit findings. Resources will be set aside for critical weaknesses but also for strategic purposes such as CMS information technology modernization, specifically contractor reform and a reduction in the number of data centers, and the introduction of enterprise security services such as intrusion detection.

The CMS continues to make progress in identifying and addressing individual weaknesses in its automated processing systems. This is accomplished through a rigorous corrective action process. All weaknesses are tracked to completion as part of the CMS Plan of Actions and Milestones (POA&M) report. CMS also is proactive in oversight of the contractors. CMS performs vulnerability assessments, Statement of Auditing Standards No. 70, Service Organizations, internal control reviews, and requires Medicare contractors to perform internal control self-assessments. The CMS has also revised its information systems security requirements. The CMS *Core Information Security Requirements* adhere to statutory requirements such as the Health Insurance and Portability Accountability Act security rule, the Federal Information Security Management Act requirements, and guidelines issued by the Office of Management and Budget (Circular A-130, *Federal Information Systems*) and the National Institute of Standards and Technology. In FY 2004, CMS required Medicare contractors to update and submit security plans. Controls were implemented to

monitor and evaluate requests for source code changes to the Fiscal Intermediary Standard System. In FY 2004, CMS also initiated additional vulnerability testing of all Medicare data centers to identify weaknesses in the claims processing networks. All weaknesses are tracked as part of the CMS POA&M report

Hundreds of security safeguards in the areas below were funded and implemented at the contractor sites based on their self-assessments and CMS' analysis of the risks associated with not meeting the requirements. Most of these safeguards were implemented in FY 2003 and 2004. All self-assessments and safeguards were reviewed and accepted by CMS prior to the distribution of funding. The CMS oversees the implementation of funding via on-site visits.

The key to resolving the material weaknesses is building a secure claims processing environment via CMS' Modernization initiative. Data center consolidation and Medicare contractor reform mandated by the Medicare Modernization Act will contribute to a more secure environment.

CMS believes its actions to fund critical vulnerabilities and increase its oversight of the contractors will be sufficient to plug the most significant gaps in security, and, as a result, mitigate the material weakness to a reportable condition. The CMS Modernization initiative is the long-term plan for addressing these security issues, e.g., by reducing the security perimeter through Medicare contractor reform and data consolidation.

Departmental Payroll System

The Human Resources Service (HRS) and the Information Technology Service Center (ITSC) are committed to addressing the audit findings proactively and implementing remedial actions in the following manner:

The Entity-Wide Security Program and logical & physical access are findings related to the network. The ITSC's management response to these findings is that the certification and accreditation (C&A)of both the Silver Spring Center LAN and the Division of Commissioned Personnel LAN was completed in June 2003. A unified ITSC network is scheduled to be established in FY 2005, and it will be authorized, certified and accredited. The unified ITSC network will have a security plan and a risk assessment will be conducted upon implementation. A C&A is planned for the Silver Spring Center computer room.

The network password faults cited are the result of a migration process from NT to Windows 2000 Active Directory that was halted during the transition to ITSC control of the network. This process will be completed by ITSC, and the settings returned to ones meeting NIST standards. Those standards will also address the password complexity issues mentioned.

The ITSC will also be implementing patch and vulnerability management products enterprise wide to ensure devices are properly patched, configured and scanned on a regular basis to ensure their security posture. In addition, the vulnerability remediation product will be capable of ensuring compliance to security templates meeting the requirements of NIST, ISO 17799, or other standards as appropriate. All of this will take place in the context of the development of a security plan and program for the ITSC's consolidated infrastructure.

For Segregation of duties and authorization & completeness, the corrective action will be to implement additional independent reviews of code moved into production. Currently, HRS is developing a plan for a database audit logging of People Tools code tables to verify that changes are only made during scheduled

code migration periods. HRS is evaluating alternative source code management packages such as Quest Software's STAT product to meet this remedial need. In addition, security for migrations will be limited to the migration lead and the migration backup individuals. All other access by Operations and Maintenance staff will be limited to read-only for any database code objects.

HRS has implemented the removal of accounts with 15 months of inactivity and conducted periodic reviews of audit operator tables (user access tables). Aged user accounts will be removed on a periodic basis. Security responsibilities will be formally documented in the updated Security Features User's Guide (SFUG) as part of the re-certification process. EHRP roles and permission lists will be reviewed and adjusted as part of the user and agency administrator re-certification.

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Appendix F – Management Report on Final Action
October 1, 2003 - September 30, 2004

Background

The Inspector General Act Amendments of 1988 (P.L. 100-504) require Departments and agencies to report to Congress on the actions they have taken and the amount of funds recovered or saved in response to the Office of Inspector General's (OIG) audit recommendations. This annual management report provides the status of OIG reports in the Department and summarizes the results of actions taken to implement OIG audit recommendations during the reporting period.

Departmental Findings

For the fiscal year covered by this report, the Department accomplished the following:

- Initiated action to recover $755 million through collection, offset, or other means (see Table I);
- Completed action to recover $518 million through collection, offset, or other means (see Table I);
- Initiated action to put to better use $1 billion (see Table II); and
- Completed action that over time will put to better use $1 billion (see Table II).

At the end of this period there are 287 reports over 1 year old with uncollected balances or unimplemented monetary findings. The reasons these reports are still pending are found in the notes to the tables.

Departmental Conflict Resolution

In the event that the HHS agencies and OIG staff cannot resolve differences on specific report recommendations, a conflict resolution mechanism is available. During FY 2004, there were no disagreements requiring the convening of the Conflict Resolution Council.

The HHS Process

Four Key Elements to the HHS Audit Resolution and Follow-up Process

- The HHS Agencies have a lead responsibility for implementation and follow-up on most OIG and independent auditor recommendations;
- The Assistant Secretary for Budget, Technology, and Finance establishes policy and monitors HHS Agencies' compliance with audit follow-up requirements;
- The audit resolution process includes the ability to appeal disallowances administratively under such programs as Head Start, Foster Care and Medicaid pursuant to the Board's regulations in 45 C.F.R. Part 16; and
- If necessary, the Assistant Secretary for Budget, Technology, and Finance or the Deputy Secretary resolves conflicts between the HHS Agencies and the OIG.

Status of Audits in the Department

In general, HHS Agencies follow up on OIG recommendations effectively and within regulatory time limits. The HHS Agencies usually reach a management decision within the 6-month period that is prescribed by P.L. 100-504 and OMB Circular A-50, *Audit Followup*. For the most part, they also complete their final actions on OIG reports, including collecting disallowed costs and carrying out corrective action plans, within a reasonable amount of time. However, the Department continues to monitor this area to improve procedures and ensure compliance with corrective action plans.

Report on Final Action Tables

The following tables summarize the Department's actions in collecting disallowed costs and implementing recommendations to put funds to better use. Disallowed costs are those costs that are challenged because of a violation of law, regulation, grant term or condition, etc. Funds to be put to better use relate to those

costs associated with cost avoidances, budget savings, etc. The tables are set up according to the requirements of Section 106(b) of P.L. 100-504.

TABLE I	Management Action on Costs Disallowed in OIG Reports As of September 30, 2004 *(in thousands)*		
		Number	Disallowed Costs
A.	Reports for which final action had not been taken by the commencement of the reporting period. See Note 1.	435	$838,943
B.	Reports on which management decisions were made during the reporting period. See Note 2.	322	$754,809
Subtotal (A+B)		757	$1,593,752
C.	Reports for which final action was taken during the reporting period:		
i.	The dollar value of disallowed costs that were recovered through collection, offset, property in lieu of cash, or otherwise.	370	$518,345
ii.	The dollar value of disallowed costs that were written off by management.	2	$175
Subtotal (i+ii)		372	$518,520
D.	Reports for which no final action has been taken by the end of the reporting period. See Note 3.	385	$1,075,232

Notes:
1. Includes adjustments of amended disallowance and disallowance excluded from the previous reporting period.
2. Represents the amount of management concurrence with the OIG's recommendations. For this fiscal year, the OIG's reconciliation with the HHS Agencies showed a variance that represents the two organizations having different cut-off dates.
3. Includes the list of audits over 1 year old with outstanding balances to be collected. Includes audits under administrative or judicial appeal, under current collection schedule, and legislatively uncollectible.

TABLE II	Management Action on OIG Reports with Recommendations That Funds Be Put to Better Use As of September 30, 2004 *(in thousands)*		
		Number	Disallowed Costs
A.	Reports for which final action had not been taken by the commencement of the reporting period. See Note 1.	12	$56,420,817
B.	Reports on which management decisions were made during the reporting period.	12	$1,331,208
Subtotal (A+B)		24	$57,752,025
C.	Reports for which final action was taken during the reporting period:		
i.	The dollar value of recommendations that were actually completed based on management action or legislative action.	11	$1,321,165
ii.	The dollar value of recommendations that management has subsequently concluded should not or could not be implemented or completed.	0	$0
Subtotal (i+ii)		11	$1,321,165
D.	Reports for which no final action has been taken by the end of the reporting period. See Note 2.	13	$56,430,860

Notes:
1. Includes adjustments of amended disallowances and disallowances excluded from the previous reporting period.
2. Includes the nine reports shown on the following page with recommendations to put funds to better use that were pending for more than 1 year. These reports involve major policy questions as well as legislative remedies that are difficult and time consuming to resolve.

Reports Containing Recommendations to Put Funds to Better Use Pending More Than 1 Year As of September 30, 2004

Audit Number	Auditee	Date Issued	Amount	Explanations
OEI-12-92-00460	Inappropriate Payments for Total Parenteral Nutrition (TPN) (ES#921222-1330)	Jun-93	$69,000,000	CMS currently is determining the actual amount of the savings.
A-06-92-00043	BC/BS of Texas, Inc. -- GME Costs	Mar-94	$4,078,960	Corrective action cannot be implemented pending the resolution of an objection lodged by the providers' legal counsel with the OIG and the Office of General Counsel.
A-04-95-02110	SC BC (Hospice of Lake & Sumter, Inc.) – ORT	Nov-96	$2,500,000	CMS is reassessing whether seeking the identified OIG hospice overpayment is the appropriate action to take.
A-06-95-00095	Palmetto Gov. Ben. Admin. (Fam. Hospice/Dallas)-ORT	Jan-97	$69,648	CMS is reassessing whether seeking the identified OIG hospice overpayment is the appropriate action to take.
A-05-95-00060	WI Department of Health and Social Services	Feb-97	$2,400,000	The State of Wisconsin plans to establish a work group to meet and review HMO financial data related to Medicaid HMOs to determine the actual amount of the savings.
OEI-03-99-00200	Medicare Payouts for Services After Death	Mar-97	$4,800,000	CMS is in the process of determining the amount of savings.
A-06-01-00053	Medicaid Pharmacy	May-02	$470,000,000	Actual acquisition costs of generic prescription drug products.
A-09-01-00109	Medicare Part B Fee Schedule Amounts	Dec-02	$171,500,000	CMS is in the process of determining the amount of savings.
A-03-00-00216	Medicaid Enhanced Payments	Nov-01	$55,497,000,000	Review to local public providers and the use of intergovernmental transfers.
	Total 9 Reports from CMS		$56,221,348,608	

HHS Audit Reports Over 1 Year Old With Outstanding Balances To Be Collected As of September 30, 2004					
HHS Agency	Audit Report #	Auditee	Issue Date	Amount	Note
ACF	02-00-64555	Utica-HS	Oct-01	$166,880	6
ACF	02-02-69503	Puerto Rico	Feb-03	$507,667	25
ACF	02-02-71356	2nd St Youth Ctr.	Feb-03	$15,034	1
ACF	02-91-14405	Bedford Stuyvesanto/O	Mar-02	$34,593	3
ACF	02-97-47637	Puerto Rico IV-B	Sep-97	$9,703	25
ACF	02-99-02005	Puerto Rico	Oct-02	$1,214,299	4
ACF	02-99-58335	Puerto Rico	Mar-99	$5,400	25
ACF	03-01-00510	Council Southern MT	Nov-01	$11,635	6
ACF	03-02-00550	Central Piedmont Act	Jun-03	$41,106	6
ACF	03-02-72227	State of VA	Jan-01	$1,100,000	1
ACF	03-03-73256	Lawrence Cty HS, Inc	Jun-03	$148,663	6
ACF	03-03-73829	Preschool Dev Prog	Jul-03	$961,497	1
ACF	03-03-74041	Child Advocates of Blair	Jun-03	$110,563	25
ACF	03-03-74937	Preschool Dev Prog	Sep-03	$448,772	6
ACF	03-97-43787	VA/CCDBG	Jun-97	$937,769	25
ACF	03-97-47731	State of DE	Sep-97	$11,880	25
ACF	03-99-03305	Research Assessment State of MD	Jul-00	$4,453,336	6
ACF	04-00-60897	State of FL	Nov-00	$33,397	25
ACF	04-00-64861	State of NC	Mar-01	$357,591	6
ACF	04-00-66032	State of FL	Jan-01	$41,989	25
ACF	04-01-68839	State of FL	Apr-02	$155,973	25
ACF	04-01-68839	State of FL	Apr-02	$7,519	25
ACF	04-91-06594	Mountain Valley/HS	Sep-92	$196,213	2
ACF	04-92-17186	Mountain Valley/HS	Sep-92	$203,420	2
ACF	04-94-30737	Mountain Valley/HS	Jul-94	$39,095	2
ACF	04-96-00105	Delta Foundation	Apr-99	$1,225,291	4
ACF	04-96-00107	Harambee Child Level	Aug-99	$124,811	6
ACF	04-97-47475	Wash Cty Opport Inc.	Nov-97	$173,151	4
ACF	04-99-56945	Quitman Cty Dev Org Inc	Jun-02	$6,375	6
ACF	04-99-59501	Chapel Hill Carrboro	Jan-02	$11,256	6
ACF	05-01-67360	MI Family Independence Agency	Jul-01	$150,000	25
ACF	05-02-70977	Nottawaseppi	Nov-02	$671	6
ACF	05-03-73080	Genesee Cty Comm Action	May-03	$14,511	25
ACF	05-03-73766	Family Dev Service	Sep-03	$20,679	25
ACF	05-97-48402	Montgomery Co CAA	Nov-97	$79,374	2
ACF	05-98-00010	State WI	Feb-00	$3,318,857	25
ACF	06-00-62531	NA Five Sandoval Indian Pueblos Inc.	Oct-00	$13,958	4
ACF	06-02-70441	Five Sandoval Indian Tribe	Apr-03	$67,998	6
ACF	06-02-72487	Kaw National of OK	May-03	$647	6
ACF	06-03-73575	Hidalgo Cty TX	Jul-03	$543,541	6
ACF	06-90-00052	Mexican Amer/Discret	Apr-92	$74,646	3
ACF	06-97-47657	Five Sandoval	Nov-99	$46,660	6
ACF	06-97-47730	Tri-County Head Start	Dec-97	$2,451	6
ACF	06-97-48284	E Texas Family Srv	Nov-98	$9,130	6
ACF	06-97-48531	TX DHS	Jan-99	$11,209	25
ACF	07-02-00138	State of NE	Sep-03	$11,681,442	1
ACF	07-02-72037	State of KS	Oct-01	$57,236	1
ACF	07-98-50741	Citizens Housing	Dec-99	$2,678	6

HHS Audit Reports Over 1 Year Old With Outstanding Balances To Be Collected As of September 30, 2004					
HHS Agency	Audit Report #	Auditee	Issue Date	Amount	Note
ACF	08-97-43975	Oglala Sioux Tribe	May-99	$6,494	6
ACF	08-99-57703	Connejos-Costil	Oct-99	$21,145	6
ACF	08-99-59825	Crow Creek Sioux Tribe	Jan-00	$26,660	6
ACF	08-99-59907	Crow Creek Sioux Tribe	Aug-00	$344,504	6
ACF	09-00-63951	Tohono O Odham Nation	May-01	$164,947	4
ACF	09-90-56270	Rinco San Luiseno Band	Apr-01	$49,460	6
ACF	09-93-00106	CA Dept. of Social Svcs.	May-97	$29,269	25
ACF	09-93-23668	Center of ED/HS	Nov-93	$12,070	25
ACF	09-95-00091	Walter McDonald Asso.	Jul-99	$23,553	4
ACF	09-96-40113	Protective & Adv Mariana	Apr-98	$80,574	6
ACF	09-96-40114	Protective & Adv Mariana	Apr-98	$36,988	6
ACF	09-96-40115	Protective & Adv Mariana	Apr-98	$56,344	6
ACF	10-00-58628	Kuigpagmiut, In.	Apr-00	$18,119	6
ACF	10-01-66783	Native Village of Mekoryuk	Apr-01	$15,883	4
ACF	10-03-72484	Maniilaq Manpower, Incak	Jul-03	$44,498	6
ACF	10-98-00008	Siletz River Co.	Apr-00	$27,316	6
		Total for ACF		$29,808,390	
CDC	01-00-62266	State of ME	Feb-00	$138,782	5
CDC	01-00-66460	State of ME	Jan-03	$363,364	5
CDC	01-02-70271	State of ME	Apr-03	$561,697	5
CDC	01-02-71527	State of MA	Apr-02	$29,260	5
CDC	01-02-73084	State of ME	Sep-02	$188,524	5
CDC	01-96-37165	Haitian American Public Health Initiative	Mar-97	$20,209	5
CDC	03-01-66421	American Assoc. of Community Colleges	Nov-00	$7,474	5
CDC	03-02-72715	DC Dept. of Health	Jul-03	$7,851	5
CDC	03-03-72847	DC Dept. of Health	Oct-02	$12,850	5
CDC	03-98-50835	Nat'l Organ. of Black County Officials	Jan-99	$19,385	5
CDC	03-98-50836	Nat'l Organ. of Black County Officials	Jan-99	$27,140	5
CDC	03-98-50837	Nat'l Organ. of Black County Officials	Mar-99	$1,078	5
CDC	03-98-51634	City of Philadelphia, PA.	Jun-98	$93,690	5
CDC	03-99-56842	Nat'l Assoc. for Equal Opport. in Higher Ed.	Feb-01	$33,585	5
CDC	04-00-61897	American Cancer Society	Mar-01	$28,654	5
CDC	04-00-65030	State of SC	Jul-00	$688,633	1
CDC	04-02-72213	State of FL	Jun-02	$28,612	5
CDC	04-98-51239	State of AL Child Care & Dev. Fund Mand.	Sep-98	$227,200	5
CDC	05-03-73921	DC Dept. of Health	Nov-02	$13,317	5
CDC	06-01-68128	City of Houston, TX	Feb-01	$56,340	5
CDC	06-02-70732	US-Mexico Border Health Association	Jan-02	$23,483	5
CDC	06-98-54189	City of Houston, TX	Jul-98	$12,096	5
CDC	09-96-41444	Immigrant Center	Mar-97	$2,495	5
CDC	10-98-53018	Self Enhancement, Inc.	May-00	$3,452	5
CDC	10-98-53162	People of Color Against AIDS Network	Sep-00	$8,289	5
		Total for CDC		$2,597,460	
CMS	01-01-00502	Ambulance & Radiology Serv	Oct-02	$51,000,000	5
CMS	01-01-00542	Associated Hospital Serv	Dec-02	$518,981	5
CMS	01-89-00518	Blue Shield of MA	Oct-90	$216,053	11
CMS	01-90-00500	Blue Cross of MA	Sep-90	$7,048,076	4
CMS	01-91-00508	Aetna Life-Parts A&B Adm.	Jan-92	$223,655	12

HHS Audit Reports Over 1 Year Old With Outstanding Balances To Be Collected As of September 30, 2004					
HHS Agency	Audit Report #	Auditee	Issue Date	Amount	Note
CMS	01-92-00517	Blue Cross of M.	Apr-93	$160,122	5
CMS	01-92-00523	BC/BS of MA -Part B Lab Tests	Jan-94	$2,250,000	26
CMS	01-93-00512	BC/BS of MA-Lab Test	Jul-94	$426,817	26
CMS	01-94-00510	BC/BS of MS - ADM costs	Apr-95	$130,299	5
CMS	01-95-00503	G/A & Capitol McLean Ho- Adm Costs	Aug-95	$186,190	5
CMS	01-96-00513	Separately Billable ESRDL Lab Tests	Dec-96	$6,300,000	5
CMS	01-96-00519	Nat'l Medical Care ESRD	Sep-97	$4,319,361	7
CMS	01-96-00527	Clinical Lab Tests- Hosp. Outpatient Labs	Dec-00	$43,632,767	5
CMS	01-98-00512	CT BC/BS Noncompliance	Jun-98	$3,264	5
CMS	01-99-00501	Waterbury Hospital	Oct-99	$103,588	5
CMS	01-99-00518	Danbury Hospital	May-00	$62,104	5
CMS	01-99-00521	Hematology Indices	Sep-00	$14,000,000	5
CMS	01-99-00522	Medicare Clinical Lab Tests	Oct-00	$31,200,000	5
CMS	01-99-00523	United HealthCare Ins.	Aug-00	$19,282	5
CMS	02-00-01023	N. Shore Long Island Jewish Hlth System	Jul-02	$319,130	5
CMS	02-00-01032	St. Barnabas Hosp	Jul-02	$205,100	5
CMS	02-00-01048	Triple S Inc.	Dec-01	$298,693	5
CMS	02-86-62015	Empire BC/BS	Mar-88	$1,277,575	9
CMS	02-86-62016	Empire BC/BS	Aug-88	$3,027,672	8
CMS	02-91-01022	Prudential Ins.-ADM	Mar-92	$6,837,167	14
CMS	02-92-01004	NJ DHS - Credit Balances for Eight Hosp	Sep-93	$89,839	5
CMS	02-96-01034	Staff Blders. Home Health Inc. Buffalo-ORT	Jan-98	$2,046,576	5
CMS	02-97-01026	Eddy VNA of the Capital Region	Nov-99	$11,336,867	5
CMS	02-97-01041	Personal Care Svc., Westchester Cty. NY	Apr-99	$687,418	5
CMS	02-99-01026	South Jersey Rehab Associates, Inc.	Nov-00	$259,068	5
CMS	03-01-00005	Veritus, Inc.	Oct-01	$131,071	5
CMS	03-92-00150	Elmira Jeffries MNH	Jan-94	$164,188	22
CMS	03-92-00201	Commonwealth of VA	Jan-93	$205,177	14
CMS	03-92-00602	PA DPW - Upper limit	Sep-94	$230,520	5
CMS	03-93-00013	Omega Med. Lab.	Nov-93	$1,102	5
CMS	03-93-00025	PBS - Lab Fee Schedules	Sep-95	$953,377	5
CMS	03-95-38380	Commonwealth of VA	Mar-96	$68,333	5
CMS	03-99-00012	John Hopkins Bayview Medical Ctr	Jun-02	$957,458	5
CMS	04-00-06005	Univ of Al at Birmingham Hospital	Apr-02	$5,428,248	5
CMS	04-00-61448	State of GA (OGM)	Feb-00	$1,032,355	24
CMS	04-00-61620	State of NC	Nov-01	$57,097	5
CMS	04-00-61627	State of TN	Mar-00	$359,907	24
CMS	04-01-68698	State of MS	Mar-02	$3,560,760	5
CMS	04-02-02016	Pitt County Memorial Hospital	Jan-03	$49,696	14
CMS	04-02-72659	State of GA	Sep-02	$142,363	5
CMS	04-94-01096	Humana Medical Plans, Inc.	Apr-95	$624,048	5
CMS	04-95-01104	American Health Care-ORT	Jan-97	$1,200,000	5
CMS	04-95-02110	SC BC (Hospice of Lake and Sumter, Inc.) ORT	Apr-97	$4,000,000	5
CMS	04-95-02111	B/C of SC (Hospice of FL Suncoast, Inc.)	Mar-97	$14,800,000	5
CMS	04-95-33005	State of MS (OGM)	Aug-95	$63,140	12
CMS	04-95-33088	State of NC (OGM)	Sep-96	$2,642	12
CMS	04-95-38310	State of MS (OGM)	Mar-96	$9,069,408	22
CMS	04-96-01125	Aetna- Rosemont Health Care Ctr	Jan-02	$55,306	5

HHS Audit Reports Over 1 Year Old With Outstanding Balances To Be Collected As of September 30, 2004					
HHS Agency	Audit Report #	Auditee	Issue Date	Amount	Note
CMS	04-96-01129	CA BC - ORT SNF of Washington Manor	Jan-02	$284,378	5
CMS	04-96-01131	Aetna (Health Svcs. Of Green Briar)-ORT	Nov-97	$202,780	5
CMS	04-96-01134	Aetna Colonnade Med. Ctr - ORT	Jan-02	$385,338	5
CMS	04-96-01135	Aetna Washington Manor ORT	Jan-02	$220,483	5
CMS	04-96-01136	Aetna Savanna Cay Manor -ORT	Jan-02	$354,537	5
CMS	04-96-01148	Aetna Life Insur. Co.	Nov-97	$148,955	5
CMS	04-96-02122	Blue Cross of GA	Oct-98	$791,327	6
CMS	04-97-01164	1996 ACR Proposal for FL MCP	Jan-00	$9,660,000	5
CMS	04-97-01168	FL Agency for Health Care Administration	Dec-99	$8,885,855	14
CMS	04-97-02130	Mutual of Omaha	Apr-99	$1,709,245	5
CMS	04-97-02138	Mutual of Omaha	Apr-99	$2,382,527	5
CMS	04-98-01184	Homebound Medical Care, Inc.	Jun-00	$1,860,760	5
CMS	04-99-01193	Six State Review of O/P Rehab. Facilities	Jun-00	$74,067,804	5
CMS	04-99-01195	Medicare Home Health Services in FL	Mar-01	$57,022	5
CMS	04-99-55388	State of NC (OGM)	Jun-99	$367,984	5
CMS	04-99-55479	Commonwealth of KY (OGM)	Mar-99	$316,997	5
CMS	04-99-55653	State of TN (OGM)	Nov-99	$309,448	5
CMS	04-99-59921	State of KY (OGM)	Oct-99	$184,633	5
CMS	05-02-72686	Ohio Dept of Job and Family Services	Jul-02	$6,323	5
CMS	05-02-72686	State's Home Care Program	Aug-02	$20,572	5
CMS	05-03-74058	Bellefaire Jewish Children's Bureau	Nov-02	$11,410	5
CMS	05-90-00013	BC/BS of MI - Admin	Dec-90	$2,413,388	10
CMS	05-97-00029	Office of Medicaid Policy and Planning - IN	Mar-99	$2,000,000	5
CMS	06-01-00039	TX Hlth & Human Serv Commission	Jun-02	$40,070	5
CMS	06-01-00077	OK Medicaid School Based Services	Oct-02	$1,902,390	25
CMS	06-01-68876	State of LA -OGM	Jun-02	$48,414	5
CMS	06-02-72136	State of LA	Jun-02	$64,870	5
CMS	06-92-00043	BC/BS of TX - GME Costs	Mar-94	$4,252,743	23
CMS	06-95-00095	Palmetto Gov. (Fam Hospice/Dallas)	Apr-97	$871,306	22
CMS	06-96-00027	Palmetto Gov. (VNA of TX Hospice)	Apr-97	$1,156,341	22
CMS	06-97-00034	Risk Base Health Maint.	Jun-99	$55,895	5
CMS	06-99-00058	State of LA (OGM)	Jun-00	$5,290,000	5
CMS	06-99-56489	State of LA (OGM)	Aug-99	$368,258	5
CMS	07-00-65149	NE Health & Human Serv Nursing Facility	Sep-00	$1,450,104	5
CMS	07-01-02616	Mutual of Omaha	Aug-01	$11,336,867	5
CMS	07-02-03017	BC-BS of NC	Feb-03	$5,305,655	18
CMS	07-03-02654	Ambulatory Surgical Centers	Dec-02	$230,545	5
CMS	07-03-02655	Ambulatory Surgical Centers	Dec-02	$92,393	5
CMS	07-03-02657	Ambulatory Surgical Centers	Dec-02	$26,785	5
CMS	07-03-02659	Ambulatory Surgical Centers	Nov-02	$2,655	5
CMS	07-03-02663	Ambulatory Surgical Centers	Jan-03	$9,338	5
CMS	07-91-00471	BC/BS of MI - Pension Seg.	Dec-92	$5,021,873	10
CMS	07-91-00473	BC/BS of FL, Inc.-Pension Seg.	Aug-93	$4,755,565	13
CMS	07-92-00525	BC/BS of MI -Pension Costs	Dec-92	$2,135,884	10
CMS	07-92-00578	BC/BS of TX - Unfunded Pension Costs	Oct-92	$6,244,637	13
CMS	07-92-00585	BS of CA - Pension Costs	Feb-94	$2,973,504	5
CMS	07-92-00604	WVA BC/BS Term Pension	Jan-93	$617,644	17
CMS	07-92-00608	BC/BS of Missouri	Jun-93	$960,615	15

HHS Audit Reports Over 1 Year Old With Outstanding Balances To Be Collected As of September 30, 2004					
HHS Agency	Audit Report #	Auditee	Issue Date	Amount	Note
CMS	07-93-00634	Travelers - Pension Seg.	Oct-93	$1,026,460	18
CMS	07-93-00665	Travelers Ins.- Pension Costs	Oct-93	$1,218,963	5
CMS	07-93-00680	BC/BS of NC - Unfunded Pension Costs	Oct-94	$293,629	21
CMS	07-93-00709	BC/BS of CT - Pension Seg.	Apr-94	$119,472	19
CMS	07-93-00710	BC/BS of CT - Pension Costs	Mar-93	$237,392	19
CMS	07-93-00713	PA BS - Pension Costs	Jun-95	$5,490,995	5
CMS	07-94-00744	IASD Health Svcs. Corp. - Pension Seg.	Sep-94	$3,079,484	20
CMS	07-94-00745	IASD Hlth Svcs. Corp. - Unfunded Pen.	May-94	$574,804	20
CMS	07-94-00746	IASD Health Svcs. Corp. - Pension Seg.	May-94	$842,979	20
CMS	07-94-00747	IASD Hlth Svcs. Corp. - Unfunded Pen.	May-94	$10,331	20
CMS	07-94-00762	Health Care Svcs. Corp - Unfunded Pen.	Jul-94	$1,233,337	10
CMS	07-94-00763	Health Care Svcs. Corp.- Pension Seg.	Aug-94	$1,055,458	10
CMS	07-94-00768	BC/BS of SC - Pension Costs	Sep-94	$840,493	13
CMS	07-94-00769	BC/BS of SC - Pension Costs	Sep-94	$329,001	19
CMS	07-94-00770	BC/BS of SC- Unfunded Pension Costs	Sep-94	$793,508	13
CMS	07-94-00777	BC/BS of GA - Pension Costs	Oct-94	$90,736	13
CMS	07-94-00778	BC/BS of GA - Unfunded Pension Costs	Oct-94	$363,921	13
CMS	07-94-00779	BC/BS of GA - Pension Seg.	Oct-94	$113,256	13
CMS	07-94-00805	BC/BS of TN -Pension Seg.	Jan-95	$1,400,063	13
CMS	07-94-00816	BC/BS of TN. -Unfunded Pension Costs	Jan-95	$352,026	13
CMS	07-94-00817	BC/BS of AL - Pension Unfunded Costs	Jul-95	$912,730	13
CMS	07-94-00818	BC/BS of AL - Pension Seg.	Jul-95	$951,281	13
CMS	07-94-01107	BC/BS of FL - Pension Seg.	Apr-96	$813,122	13
CMS	07-95-01126	BC/BS of FL - Pension Unfunded Costs	Apr-96	$4,049,889	13
CMS	07-95-01149	BC/BS of TX - Pension Costs	Apr-96	$874,111	13
CMS	07-95-01150	BC/BS of Oregon - Pension Seg.	Aug-97	$191,312	5
CMS	07-95-01159	BC/BS of NE - Pension Seg.	Jan-96	$96,955	27
CMS	07-95-01166	BC/BS of NE - Pension Unfunded Costs	Jan-96	$73,509	27
CMS	07-96-01189	BC of WA & AK- Pension Seg.	Dec-97	$96,740	5
CMS	07-96-01194	Community Mutual Ins. Co. Pension Seg.	Jul-97	$1,866,026	5
CMS	07-97-01205	BC of WA & AK - Pension Seg.	Dec-97	$15,688	5
CMS	07-97-01206	BC of WA & AK - Pension Unfunded Costs	Dec-97	$106,843	5
CMS	07-97-01207	Community Mutual Ins. Co. Unfunded Pen	Sep-00	$571,413	5
CMS	07-97-01208	Community Mutual Ins Co Pension Costs	Sep-00	$991,972	5
CMS	07-97-01209	BC/BS of MS - Pension Seg.	Jan-98	$224,711	13
CMS	07-97-01210	BC/BS of MS - Unfunded Pension Costs	Jan-98	$482,549	13
CMS	07-97-01211	BC/BS of MS - Pension Costs	Jan-98	$134,312	13
CMS	07-97-01213	Travelers Pension Seg.	Jan-98	$5,624,747	5
CMS	07-97-01222	AdminaStar Federal of KY - Pension Seg.	Oct-98	$1,236,890	13
CMS	07-97-02500	Anthem BC/BS of CT	Mar-98	$122,548	5
CMS	07-98-01224	AdminaStar Federal - Unfunded Pension	Oct-98	$4,286,294	5
CMS	07-98-01225	AdminaStar Federal - Pension Costs	Oct-98	$736,134	5
CMS	07-98-02501	Anthem BC/BS of CT - Unfunded Pension	Mar-98	$292,152	5
CMS	07-98-02522	BS of CA - Pension Plan Terminated	Apr-99	$7,623,524	5
CMS	07-99-01278	Rebound Inc.	Apr-02	$1,042,522	5
CMS	07-99-01288	Wellmark, Inc.	Nov-01	$1,169	5
CMS	07-99-02540	General American Life Insurance Company	Jul-00	$6,205,564	27
CMS	08-00-64575	State of CO	May-00	$11,205,906	13

HHS Audit Reports Over 1 Year Old With Outstanding Balances To Be Collected As of September 30, 2004					
HHS Agency	Audit Report #	Auditee	Issue Date	Amount	Note
CMS	08-94-00739	BC/BS of ND - Pension Seg.	Jan-95	$730,875	13
CMS	08-94-00740	BC/BS of NC - Unfunded Pension Costs	Jan-95	$671,198	13
CMS	09-89-00162	Nationwide Employer Project - MSP	Mar-95	$2,218,824	16
CMS	09-95-00072	CA DHS	Nov-96	$4,013,490	5
CMS	09-96-00061	BS of CA	Jun-98	$1,006,192	18
CMS	09-96-00064	San Diego Hospice Corp. - ORT	Nov-98	$993,779	5
CMS	09-96-00088	Care Providers- BC of CA	Jul-99	$901,278	5
CMS	09-96-00089	Care Plus Home Hlth Services - BC of CA	Jul-99	$389,497	5
CMS	09-96-00094	BC of Ca - Dynasty Home Hlth Inc	Jan-02	$217,720	5
CMS	14-96-00202	Excluded Unlicensed Health Care Providers	Sep-97	$2,931	5
CMS	17-95-00096	HCFA Financial Statement Audit for FY 1996	May-98	$300,000	5
CMS	17-97-00097	HCFA Financial Statement Audit for FY 1997	Sep-98	$141,796	5
		Total for CMS		$475,082,478	
HRSA	04-98-50281	Aaron E. Henry CHC	Sep-98	$3,017	6
HRSA	08-02-70421	Aberdeen Area Tribal Chairmen's Hlth Board	Feb-03	$1,509	6
		Total for HRSA		$4,526	
IHS	08-00-56759	SD Urban Indian Health	Nov-99	$32,783	5
IHS	08-00-59899	SD Urban Indian Health	Nov-99	$6,818	5
IHS	08-00-60654	Spirit Lake	Jan-00	$22,031	5
IHS	08-00-61777	Turtle Mountain Band of Chippewa Indians	Nov-99	$129,070	5
IHS	08-99-55284	SD Urban Indian Health	Jun-99	$902,046	5
IHS	08-99-55285	SD Urban Indian Health	Jun-99	$902,377	5
IHS	08-99-56446	Sisseton-Wahpeton Sioux Tribe	May-99	$5,843	5
IHS	09-00-60032	Lovelock Paiute Tribe	Dec-99	$74,187	5
IHS	09-01-65664	Lovelock Paiute Tribe	Dec-00	$50,473	5
IHS	09-01-67778	Lovelock Paiute Tribe	Jun-01	$19,129	5
IHS	09-01-68215	Pyramid Lake Paiute Tribe	Sep-01	$14,919	5
		Total for IHS		$2,159,676	
OPHS	03-02-72652	National Assoc for Equal Opportunity	Jun-02	$313,256	5
OPHS	03-03-74002	Minority Access Inc	Oct-02	$8,113	5
OPHS	03-04-75382	National Hispanic Medical Assoc.	Mar-03	$10,505	28
OPHS	03-04-76133	Minority Access Inc	Jun-03	$11,141	28
OPHS	06-03-74833	Amigo Volunteers in Education & Services	Jan-03	$31,180	28
OPHS	08-03-74361	Porcupine Clinic	Nov-02	$12,611	28
OPHS	08-03-74833	Porcupine Clinic	Nov-02	$65,027	28
OPHS	15-01-20002	Congress Heights	May-01	$11,300	28
		Total for OPHS		$463,133	
OS	01-01-00004	State of ME	Sep-01	$4,047	4
OS	02-99-02004	Puerto Rico	Sep-01	$15,601,255	6
OS	03-00-63670	State of PA	Nov-00	$11,388,686	1
OS	06-00-61716	TX Dept. of Health	Sep-00	$138,870	6
OS	08-99-59826	Crow Creek Sioux Tribe	Feb-00	$14,448	6
OS	09-97-48247	Karidat	Dec-97	$50,612	1
OS	09-97-48966	Karidat	Jan-98	$2,234	1
OS	09-98-52613	Marianas	Dec-98	$639,432	6
OS	09-99-57597	Bear River Band	Mar-00	$1,648	6
OS	09-02-70938	Pascua Yaqui Tribe of Arizona	Jun-02	$1,729	6
OS	09-02-72300	State of CA	Jul-02	$577,441	6

HHS Audit Reports Over 1 Year Old With Outstanding Balances To Be Collected As of September 30, 2004					
HHS Agency	Audit Report #	Auditee	Issue Date	Amount	Note
OS	10-02-71415	Nooksack Indian Tribe	Dec-02	$78,313	5
		Total for OS		$28,498,715	
PSC/DCA	03-90-00453	State of WV	Mar-91	$12,850,856	7
PSC/DCA	06-99-59584	State of LA	Sep-00	$19,261,661	1
		Total for PSC		$32,112,517	
SAMHSA	02-99-02502	Southeast Queens Community Partnership, Inc.	May-00	$500,263	2
SAMHSA	04-04183	Columbus Co. Services Mgmt.	Jul-94	$35,167	4
		Total for SAMHSA		$535,430	
		Total for HHS		$571,262,325	

Notes:

1. Appeal process.
2. Referred to Department of Justice (DOJ).
3. Referred to DOJ/payment plan.
4. Payment plan.
5. Pursuing collection.
6. Transferred to Treasury Offset Program.
7. In District Court.
8. Contractor has signed the closing agreement. An amended OCD is being prepared.
9. Contractor appealed and court ruled in contractor's favor. HHS agency has appealed.
10. Pending resolution of contractor's termination audit, any related termination agreement and pending lawsuit.
11. HHS agency has instructed the carrier to calculate and recover partial overpayments. Recoupment is still on hold pending resolution of the company's appeal to an administrative law judge.
12. Additional documentation has been provided by the State or contractor. OIG and/or HHS Agency reviewing.
13. HHS agency is working with all Medicare providers to obtain signed advance agreements which set forth the terms and conditions of the amended Cost Accounting Standards (CAS 412). Implementation of the advance agreements will subsume and close out the currently outstanding pension audits.
14. HHS agency is in process of negotiating or determining outstanding overpayment amount and/or payment options.
15. HHS agency will verify that corrective action has been completed by the fiscal intermediary.
16. Demand letters were sent to employers listed in the audit. D.C. Circuit Court's decision in HIAA vs. Shalala case will result in few recoveries of funds from EGHP's timely filing limits. HHS agency is attempting to “fix” the HIAA decision via new legislation.
17. Contractor was declared insolvent and placed in receivership. DOJ has filed a claim on HHS agency's behalf.
18. HHS Agency is negotiating a settlement with the State or the contractor.
19. HHS Agency is of developing a formula to settle all waivers regarding pension segmentation and/or unfunded pension costs.
20. HHS Agency is awaiting verification from the pension actuarial staff that an adjustment was made.
21. An on-site audit is in process. A global settlement will close pension and administrative costs.
22. The State or contractor is in the process of determining or collecting overpayment.
23. Collection activity has been suspended pending resolution of an objection lodged by two providers' legal counsel with the OIG and the Office of General Counsel.
24. HHS agency is verifying collection of overpayment.
25. Awaiting confirmation that account receivable may be closed out.
26. Waiting for a decision and/or action by the Asst. U.S. Attorney.
27. HHS agency is negotiating with the contractor on the related administrative costs audit.
28. HHS agency to examine related claims.
29. Working with new Executive Director to resolve all issues.

Appendix G – Civil Monetary Penalties

Civil monetary penalties (CMP) are non-criminal penalties for violation of Federal law. The Federal Civil Penalties Inflation Adjustment Act of 1990 provides for periodic evaluation to ensure that CMP maintain their deterrent value and that the imposed penalties are properly accounted for and collected. During FY 2004, only the Centers for Medicare & Medicaid Services (CMS) and the Food and Drug Administration (FDA) imposed CMP.

Civil Monetary Penalties
For the Fiscal Year Ended September 30, 2004

CMS & FDA Combined

Outstanding Receivables	Number	Amount (in Dollars)
Beginning Balances	212	$ 499,029,300
Assessments (+)	1,673	$ 851,210,756
Collections (-)	(1,151)	$ (873,394,164)
Adjustments	(216)	$ (63,440,916)
Amounts Written Off	0	$ -
Ending Balance	**518**	**$ 413,404,976**
Current Receivables	390	$ 406,395,331
Non-Current Receivables	128	$ 7,009,645
Allowance	0	$ (399,287,926)
Net Receivables	518	$ 14,117,050
Total Delinquent	**48**	**$ 3,194,531**
Total Non-Delinquent	**470**	**$ 410,210,445**

Enforcement Actions*	Number	Amount (in Dollars)
Assessed (Total)	**5**	**$ 2,252,182**
a. Small Entity	4	$ 1,233,432
b. Other	1	$ 1,018,750
Reduced or Waived (Total)	**1**	**$ 34,856**
a. Small Entity	0	$ -
b. Other	1	$ 34,856

* Includes FDA only. CMS data unavailable at time of report production.

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Appendix H – Financial Management Performance Measures

Measure	Baseline	Performance Trend					
		FY 2000	FY 2001	FY 2002	FY 2003	FY 2004 Target	FY 2004 Actual
Audited financial statements for HHS and CMS are submitted to OMB by submission due date.	FY 1996: No	Yes	Yes	Yes	Yes	Yes	No
Number of Department-level material weaknesses outstanding at end of FY. (See Appendix D for discussion)	FY 1996: 5	2 Financial systems and processes & Medicare EDP controls	2 Financial systems and processes and Medicare EDP controls	2 Financial systems and processes and Medicare EDP controls	2 Financial systems and processes and Medicare EDP controls	2 Financial systems and processes and Medicare EDP controls	2 Financial systems and processes and Medicare EDP controls
Number of Department-level reportable conditions outstanding at end of FY. (See Appendix D for discussion)	FY 1997: 3	2 Medicaid improper payments and EDP	3 Medicaid improper payments; departmental information systems controls; and management systems planning and development	1 Departmental information systems controls	1 Departmental information systems controls	1 Departmental information systems controls	3 Departmental information systems controls; omission and delays in obtaining documentation; and internal controls over departmental payroll system
Percentage of Medicare contractors that will be subject to a SAS 70.	FY 2000: 26 of 50	50%	32%	50%	48%	33%	40%
Number of Department-level instances of FFMIA noncompliance.	FY 1997: 4	2	2	2	2	2	3
Percent of vendor payments made on time.	FY 1998: 91%	96.6%	97.7%	98.3%	97.4%	97.0%	97.1%
Increase percent of debt collection over prior year.	FY 1998: $13.3 billion	$15.3 billion 7.2% increase	$14.4 billion 5.8% decrease	$14.4 billion	$16.1 billion 11.8% increase	10% increase	$ 11.3 billion as of June 30, 2004
Percent of eligible non-waived delinquent debt referred for cross-servicing to the Treasury.	FY 1998: 0%	41.9%	67.8%	93.5%	95.0%	100.0%	97.6% as of June 30, 2004
Number of Department-level FMFIA material weaknesses/nonconformances pending at year-end. Sections 2 and 4.	FY 1997: Sec 2 - 7 Sec 4 – 0	Sec 2 - 5 Sec 4 - 0	Sec 2 - 2 Sec 4 - 1	Sec 2 - 1 Sec 4 – 1	Sec 2 - 0 Sec 4 – 1	Sec 2 - 0 Sec 4 - 1	Sec 2 - 3 Sec 4 – 1

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Appendix I – Program Assessment Rating Tool (PART)

Summary of PART Ratings

As reported in the Fiscal Year 2005 Budget of the U.S. Government; Performance and Management Assessments, pages 142-185

Program	HHS Agency	Overall Rating
317 Immunization Program	CDC	Adequate
Agency for Toxic Substances and Disease Registry	ASTDR	Adequate
CDC State and Local Preparedness Grants	CDC	Results Not Demonstrated
Children's Hospitals Graduate Medical Education Payment Program	HRSA	Adequate
Children's Mental Health Services	SAMHSA	Moderately Effective
Chronic Disease - Breast and Cervical Cancer	CDC	Adequate
Chronic Disease – Diabetes	CDC	Adequate
Community Mental Health Services Block Grant	SAMHSA	Adequate
Community Services Block Grant	ACF	Results Not Demonstrated
Data Collection and Dissemination	AHRQ	Moderately Effective
Developmental Disabilities Grant Programs	ACF	Adequate
Domestic HIV/AIDS Prevention	CDC	Results Not Demonstrated
Food and Drug Administration	FDA	Moderately Effective
Foster Care	ACF	Adequate
Head Start	ACF	Results Not Demonstrated
Health Alert Network	CDC	Adequate
Health Care Fraud and Abuse Control	OIG	Results Not Demonstrated
Health Centers	HRSA	Effective
Health Professions	HRSA	Ineffective
HIV/AIDS Research	NIH	Moderately Effective
Hospital Preparedness Grants	HRSA	Results Not Demonstrated
IHS Federally-Administered Activities	IHS	Moderately Effective
IHS Sanitation Facilities Construction Program	IHS	Moderately Effective
Low Income Home Energy Assistance Program	ACF	Results Not Demonstrated
Maternal and Child Health Block Grant	HRSA	Moderately Effective
Medicare	CMS	Moderately Effective
Medicare Integrity Program	CMS	Effective
National Health Service Corps	HRSA	Moderately Effective
Nursing Education Loan Repayment and Scholarship Program	HRSA	Adequate
Office of Child Support Enforcement	ACF	Effective
Patient Safety	AHRQ	Adequate
Projects for Assistance in Transition from Homelessness	SAMHSA	Moderately Effective
Refugee and Entrant Assistance	ACF	Adequate
Resource and Patient Management System	IHS	Effective
Runaway and Homeless Youth	FYSB	Results Not Demonstrated
Rural Health Activities	HRSA	Adequate
Ryan White	HRSA	Adequate
State and Community-Based Services Programs on Aging	AoA	Moderately Effective
State Children's Health Insurance Program	CMS	Adequate
Substance Abuse Prevention and Treatment Block Grant	SAMHSA	Ineffective
Substance Abuse Treatment Programs of Regional and National Significance	SAMHSA	Adequate
Translating Research into Practice	AHRQ	Adequate
Urban Indian Health Program	IHS	Adequate

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Appendix J - Acronyms

A	ACF	Administration for Children and Families
	ACIP	Advisory Committee on Immunization Practices
	AFCARS	Adoption and Foster Care Analysis and Reporting System
	AFS	Automated Financial Statement
	AFPS	Accounting for Pay System
	AHCPR	Agency for Health Care Policy and Research
	AHRQ	Agency for Healthcare Research and Quality
	AICPA	American Institute of Certified Public Accountants
	AIDS	Acquired Immunodeficiency Syndrome
	AoA	Administration on Aging
	AR/AP	Accounts Receivable/Accounts Payable
	ASP	Average Sale Price
	ATSDR	Agency for Toxic Substances and Disease Registry
	AWP	Average Wholesale Price
	AZT	Zidovudine
B	BACS	Budget and Accounting Classification Structure
	BCCPTA	Breast and Cervical Cancer Prevention and Treatment Act of 2000
	BPD	Bureau of Public Debt
	BSC	Balanced Scorecard
C	C&A	Certification and Accreditation
	CAN	Common Accounting Number
	CARE	Comprehensive AIDS Resources Emergency
	CDC	Centers for Disease Control and Prevention
	CDRH	Center for Device and Radiological Health
	CERT	Comprehensive Error Rate Testing
	CFBCI	Center for Faith-Based and Community Initiatives
	CFO	Chief Financial Officer
	CFR	Code of Federal Regulations
	CIA	Corporate Integrity Agreement
	CIO	Chief Information Officer
	CMP	Civil Monetary Penalties
	CMS	Centers for Medicare & Medicaid Services (formerly HCFA)
	COL	Cost of Living
	CORE	PSC Core Financial Management System
	COTS	Commercial Off-The-Shelf
	CPIM	Consumer Price Index Medical
	CRADA	Cooperative Research and Development Agreement
	CRP	Conference Room Pilot

	CSE	Child Support Enforcement
	CSRS	Civil Service Retirement System
	CY	Calendar Year
D		
	DASIS	Drug Abuse Services Information System
	DC	District of Columbia
	DCIA	Debt Collection Improvement Act of 1996
	DFO	Division of Financial Operations
	DFAS	Defense Finance and Accounting Service
	DHS	Department of Homeland Security
	DMERC	Durable Medical Equipment Center
	DNA	Deoxyribose Nucleic Acid
	DOE	Department of Energy
	DOJ	Department of Justice
	DOL	Department of Labor
	DR	Disaster Recovery
	DTaP	Diphtheria Tetanus acellular Pertussis
	DUNS	
E	EBDP	Entitlement Benefits Due and Payable
	e-Gov	Electronic Government
	EDP	Electronic Data Processing
	EPA	Environmental Protection Agency
	Epi-X	Epidemic Information Exchange
F	FACES	Family And Child Experiences Survey
	FACS	Financial Accounting Control Systems
	FACTS II	Federal Agencies' Centralized Trial-Balance System II
	FAIR	Federal Activities Inventory Reform
	FASAB	Federal Accounting Standards Advisory Board
	FCRA	Federal Credit Reform Act of 1990
	FDA	Food and Drug Administration
	FECA	Federal Employees' Compensation Act
	FERS	Federal Employees Retirement System
	FFMIA	Federal Financial Management Improvement Act of 1996
	FFS	Fee-for-Service
	FI	Fiscal Intermediary
	FICA	Federal Insurance Contribution Act
	FIFO	First In, First Out
	FMFIA	Federal Managers' Financial Integrity Act of 1982
	FRPC	Federal Real Property Council

	FTE	Full-Time Equivalent
	FY	Fiscal Year

G	GA	Georgia
	GAAP	Generally Accepted Accounting Principles
	GAO	Government Accountability Office
	GATES	Grants Administration, Tracking, and Evaluation System
	GISRA	Government Information Security Reform Act
	GLAS	General Ledger Accounting System
	GMRA	Government Management Results Act
	GPO	Government Printing Office
	GPRA	Government Performance and Results Act of 1993
	GSA	General Services Administration

H	HapMap	Haplotype Map
	HBAIC	Hemoglobin
	HCFA	Health Care Financing Administration (now CMS)
	HCFAC	Health Care Fraud and Abuse Control
	HCGLP	Health Center Guarantee Loan Program
	HEAL	Health Education Assistance Loan
	HEW	Department of Health, Education and Welfare
	HHS	Department of Health and Human Services
	HI	Hospital Insurance
	Hib	Haemophilus Influenzae type B
	HIFA	Health Insurance Flexibility and Accountability
	HIGLAS	Healthcare Integrated General Ledger Accounting System
	HIPAA	Health Insurance Portability and Accountability Act
	HIV	Human Immunodeficiency Virus
	HPMP	Hospital Payment Monitoring Program
	HR	Human Resources
	HRSA	Health Resources and Services Administration

I	IBNR	Incurred But Not Reported
	IDDA	Intra-Departmental Delegations of Authority
	IG	Inspector General
	IHS	Indian Health Service
	IMPAC	Information for Management, Planning, Analysis, and Coordination
	IP	Improper Payment
	IPA	Independent Public Accountants
	IPIA	Improper Payments Information Act
	ISA	Interconnection Security Agreement
	IT	Information Technology

	ITSC	Information Technology Service Center
J		
	JFMIP	Joint Financial Management Improvement Program
K		
L	LAN	Local Area Network
	LLP	Limited Liability Partnership
	LRN	Laboratory Response Network
M	M&M	Mortality and Morbidity
	MACCS	Managing and Accounting Credit Card System
	MC	Managed Care
	MD	Maryland
	MedSun	Medical Product Surveillance and Radiological Health Network
	MIP	Medical Integrity Program
	MK	Market-based
	MMA	Medicare Prescription Drug, Improvement and Modernization Act 0f 2003
	MMR	Measles, Mumps, and Rubella
N	N/A	Not Applicable
	NACHGR	National Advisory Council for Human Genome Research
	NBRSS	NIH Business and Research Support System
	NBS	NOH Business System
	NCP	Non-Custodial Parent
	NHGRI	National Human Genome Research Institute
	NIAID	National Institute of Allergy and Infectious Diseases
	NIH	National Institutes of Health
	NIS	National Immunization Survey
	NMEP	National Medicare & You Education Program
	NQMC	National Quality Measures Clearinghouse
O	OAA	Older Americans Act
	OACT	Office of the Actuary
	OASDI	Old-Age, Survivors, and Disability Insurance (Social Security)
	OGC	Office of General Counsel
	OGMP	Office of Grants Management and Policy

	OIG	Office of Inspector General
	OMB	Office of Management and Budget
	OPM	Office of Personnel Management
	OS	Office of the Secretary
P	PAM	Payment Accuracy Measurement
	PAR	Performance and Accountability Report
	PARIS	Public Assistance Reporting Information System
	PART	Program Assessment Rating Tool
	PCV	Pneumococcal Conjugate Vaccine
	PDUFA	Prescription Drug User Fee Amendments of 2002
	PERM	Medicaid Payment Error Rate Measurement
	PHIN	Public Health Information Network
	PHS	Public Health Service
	PIP	Program Improvement Plan
	P.L.	Public Law
	PMA	President's Management Agenda
	PMO	Program Management Office
	PMS	Payment Management System
	POA&M	Plan of Action and Milestones Report
	PP&E	Property, Plant and Equipment
	PPS	Prospective Payment System
	PRWORA	Personal Responsibility and Work Opportunity Reconciliation Act of 1996
	PSC	Program Support Center
	PTF	Payments to the Health Care Trust Funds
Q	QIO	Quality Improvement Organization
R	R&D	Research and Development
	RAMP	Real Property Asset Management Plan
	RSSI	Required Supplementary Stewardship Information
S	SACWIS	Statewide Automated Child Welfare Information System
	SAMHSA	Substance Abuse and Mental Health Services Administration
	SARS	Severe Acute Respiratory Syndrome
	SAS	Statement of Accounting Standards
	SBR	Statement of Budgetary Resources
	SCHIP	State Children's Health Insurance Program
	SDPI	Special Diabetes Program for Indians
	SECA	Self-Employment Contribution Act
	SEDS	Statistical Enrollment Data System

	SES	Senior Executive Service
	SFFAS	Statement of Federal Accounting Standards
	SMI	Supplementary Medical Insurance
	SNP	Single Nucleotide Polymorphisms
	SNS	Strategic National Stockpile
	SOF	Statement of Financing
	SOP	Standard Operating Procedures
	SSA	Social Security Administration
	TANF	Temporary Assistance for Needy Families
	TEDS	Treatment Episode Data Set
	TOP	Treasury Offset Program
	TOPS	Total On-Line Processing System
	TPR	Termination of Parental Rights
	Treasury	Department of the Treasury
	TROR	Treasury Report on Receivables
	TSP	Thrift Savings Plan
	TWWIA	Ticket to Work and Work Incentives Act of 1999
U	UFMS	Unified Financial Management System
	US	United States
	USAMRIID	U.S. Army Medical Research Institute of Infectious Diseases
	USPSTAF	United States Preventive Services Task Force
	USSGL	United States Government Standard General Ledger
V	VCP	Vaccines for Children Program
	VICP	Vaccine Injury Compensation Program

W, X, Y, and Z

Appendix K – Key HHS Financial Management and Performance Officials

Kerry Weems
Principal Deputy Assistant Secretary for Budget, Technology, and Finance and Acting Chief Financial Officer

George Strader
HHS Deputy Chief Financial Officer

Administration for Children and Families (ACF)
Wade F. Horn, Assistant Secretary for Children and Families
Curtis Coy, Chief Financial Officer

Agency for Healthcare Research and Quality (AHRQ)
Carolyn M. Clancy, Director
Robert Graham, Chief Financial Officer

Administration on Aging (AoA)
Josefina G. Carbonell, Assistant Secretary for Aging
Michael Mangano, Chief Financial Officer

Centers for Disease Control and Prevention (CDC)
Julie Louise Gerberding, Director
Barbara Harris, Chief Financial Officer

Centers for Medicare & Medicaid Services (CMS)
Mark B. McClellan, Administrator
Timothy B. Hill, Chief Financial Officer

Food and Drug Administration (FDA)
Lester Crawford, Acting Commissioner
Jeffrey Weber, Chief Financial Officer

Health Resources Services Administration (HRSA)
Elizabeth M. Duke, Administrator
Steven Pelovitz, Acting Chief Financial Officer

Indian Health Service (IHS)
Charles W. Grim, Interim Director
Daniel Madrano, Acting Chief Financial Officer

National Institutes of Health (NIH)
Elias A. Zerhouni, Director
Colleen Barros, Acting Chief Financial Officer

Program Support Center (PSC)
J. Philip VanLandingham, Director
Larry Bedker, Chief Financial Officer

Substance Abuse and Mental Health Services Administration (SAMHSA)
Charles G. Curie, Administrator
Daryl Kade, Chief Financial Officer

Performance and Accountability Management and Staff

Office of Finance

George Strader	Deputy Chief Financial Officer
Shirl Ruffin	Director, Office of Financial Policy
Karen Cavanaugh	Director, Division of Financial Management Policy
Vacant	Director, Division of Accounting and Fiscal Policy
Tom Doherty	Director, Office of Program Management and Systems Policy
Margie Yanchuk	Director, Division of Financial Systems Policy
Jean Augustine	Director, Office of Audit Resolution and Cost Policy

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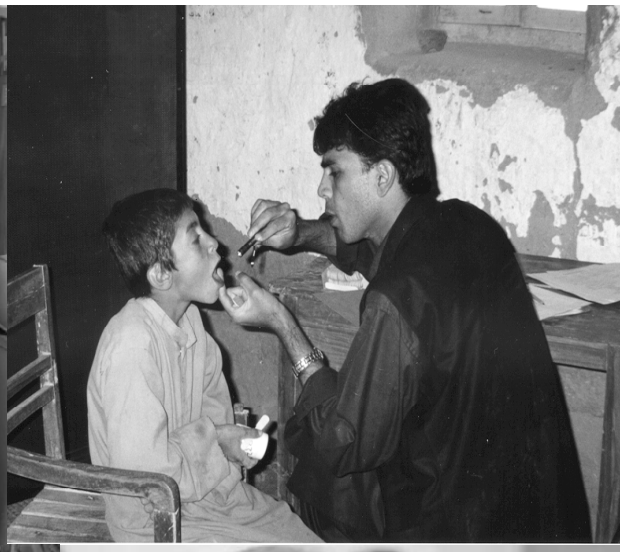

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